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IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1994

FLOYD T. BRYAN, and
FLOYD T. BRYAN, M.D., P.A., Petitioners,

v.

JAMES E. HOLMES REGIONAL MEDICAL CENTER,
a/k/a HOLMES REGIONAL MEDICAL CENTER, INC.,
Respondent.

APPENDIX TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

VOLUME II

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Q. And do you continue to be Chief of Surgery?

A. Yes.

Q. Are these elections contested like, I mean do you have a Ross Perot that pops up or do you just get elected every year?

A. Anybody had that much money, they wouldn't run for Chief of Surgery.

Q. Have you ever been opposed as Chief of Surgery?
A. No.

Q. Do you also hold a position on the Board of Directors of the hospital -- is it Board of Directors or Board of Trustees? Which is right?
A. Your choice; we usually say Board of Directors.

Q. Are you a director of the hospital?
A. Yes.

Q. How long have you been a director of the hospital?
A. Since I believe 1986.

Q. What are your duties as the director of the hospital?

A. As a director of the hospital, to sit on the Board of the hospital, to hear the business of the hospital and enact on business that comes before it.

Q. And in your capacity as a director of the hospital then, is your involvement more in the

vascular surgery at Holmes Regional Medical Center?

A. Again, Dr. Armstrong wins with five hundred and forty four, he's the highest number, and I am the second highest with five hundred three with pretty close range, Dr. Jackosn, [*sic*] four ninety, Dr. Tenewitz, four hundred and ninety six.

Q. All right, sir. Moving on, sir.

Dr. Gurri, you have in the past attended, based upon your positions at Holmes Regional, and just so that we have this all put together, up until today what positions have you held of authority for the medical staff or on the board?

A. I was Secretary Treasurer of the Medical Staff, Vice President of the Medical Staff, President of the Medical Staff, subsequently serving on the Executive Committee for two years as immediate past President.

Q. And have you become a member of the Board at any time, Board of Directors?

A. No.

Q. Have you appeared from time to time before the Board?

A. The Chief of Staff appears on the Board.

Q. So the answer is yes?

A. Well, he's not a member of the Board. He

attends the board meetings, but he's not a member.

Q. That was my question. You have appeared in that capacity before the Board of Directors?

A. That's correct.

Q. All right. Now, sir, you have attended seminars dealing with the issues of due process, conspiracy, fair hearing, adherence to the by-laws, you have done that in the past, haven't you, sir?

A. I have attended medical staff issue education courses that did cover these subjects.

Q. And in fact, you attended one in 1987 in Santa Fe, New Mexico, isn't that correct?

A. That's correct.

Q. And who went with you sir?
A. Mr. Wilford, who was the President of the hospital, the administrator of the hospital, Mr. Storms, Dr. Foley. Oh, and Mr. Sullivan, Mr. Sullivan went too.

Q. And who paid for the seminar, the trip, the lodging?
A. The hospital did.

Q. And who put on the seminar?
A. It was the law firm of John Horty.

Q. The law firm of Horty, Springer and Mather in Pittsburgh, Pennsylvania, correct?

Q. Now, Dr. Foley, who is the medical director of the hospital, is the same Dr. Foley that you have told counsel for the hospital would push your hand aside with a retractor?

A. Uh-huh.

Q. That's a yes?
A. Yes, yes, I'm sorry. Yes.

Q. And the same one that had yelled at you?
A. Yes.

Q. And had a temper?
A. Yes.

Q. And yet he has been made the director of medicine at the hospital and not suspended?
A. Right.

Q. To your knowledge, did either Sarnowski or any of the other doctors, they were all good surgeons, too?
A. Yes.

Q. Did they ever lose their staff privileges?
A. No.

Q. Dr. Armstrong and Dr. Gurri and Dr. Foley, in your opinion as a member of the hospital operating room suite, are they powerful politically?
A. Yes.

MR. KAY: Objection.
BY MR. MOSS:

HOLMES REGIONAL MEDICAL CENTER

General Surgery
1988 - 1991

Physician	1988	1989	1990	1991
Ali	58	79	86	56
Alper	.	.	161	93
Armstrong	376	450	502	544
Bryan	171	145	85	.
Collins	.	.	115	264
Gurri	309	292	427	495
Jackson	866	708	841	490
Patel	292	348	409	325
Shamma	.	.	0	11
Tenewitz	309	333	354	416
Vitale	300	320	362	359
TOTAL	2681	2675	3342	3053

HOLMES REGIONAL MEDICAL CENTER

General/Vascular Surgery

1988 - 1991

Physician	1988	1989	1990	1991
Ali	71	91	104	67
Alper	.	.	161	96
Armstrong	376	450	502	544
Bryan	314	239	122	.
Collins	.	.	156	318
Gurri	345	340	461	503
Jackson	866	708	841	490
Patel	292	348	409	325
Shamma	.	.	162	329
Tenewitz	386	435	484	496
Vitale	366	378	433	405
TOTAL	3016	2989	3835	3573

Q. All right. Now, let's start off in 1988. How many General Surgeries did Dr. Gurri, yourself, do in 1988?

A. Three hundred and nine.

Q. How many did Dr. Bryan do?
A. One Hundred and seventy one.

Q. And how many did Dr. Armstrong do?
A. Three hundred and seventy six.

Q. Moving on, same question, 1989. How many did Dr. Gurri do?

A. Two hundred and ninety two.

Q. Dr. Bryan.

A. One forty five. Dr. Armstrong, four fifty.

Q. 1990, same question, please.
A. I did four hundred and twenty seven. Dr. Bryan eighty five. Dr. Armstrong, five hundred and two.

Q. 1991, please, sir.
A. I did four hundred and ninety five. Dr. Bryan did none. Dr. Armstrong did five hundred and forty four.

Q. Who were the top two performers of General Surgery according to this document in the year 1991 at Holmes Regional Medical Center?
A. Dr. Armstrong with five hundred and forty four and I beat out Dr. Jackson by five cases with four

hundred and ninety five.

Q. How much of an increase, Dr. Gurri, according to this document, was there between 1988 when you did three hundred and nine and 1991 when you did four ninety five?

A. That's a hundred and eighty six cases.

Q. More?

A. More.

Q. And how about Dr. Armstrong, same question, how many more did he do comparing '88 to '91, how many more?

A. Sir, I don't have the calculator, it's not fair, but --

Q. Well, it's just five forty four, subtracting three seventy six, how many is that?

A. A hundred and sixty six. A hundred and sixty eight.

Q. Third page, sir. What's that entitled?

A. General/Vascular Surgery, Holmes Regional Medical Center, 1988, 1991.

Q. All right, sir. Same procedure.
A. 1988.

Q. Yes. How many did Dr. Gurri do?
A. Three hundred and forty five. Dr. Bryan, three hundred and fourteen. Dr. Armstrong, three hundred

and seventy six.

Q. Same question, please, for 1989.

A. Dr. Gurri, three forty. Dr. Bryan, two hundred and thirty nine. Dr. Armstrong, four hundred and fifty.

Q. Same question please, for 1990.

A. Myself, four hundred and sixty one. Dr. Bryan, a hundred and twenty two. Dr. Armstrong, five hundred and two.

Q. And for 1991, same question.

A. Myself, five hundred and three. Dr. Bryan, none. Dr. Armstrong, five hundred and forty four.

Q. Dr. Gurri, how much increase was there between 1988 and 1991 as to Dr. Gurri by way of increase in the number of procedures, General Vascular Surgery, at Holmes Regional?
A. A hundred and fifty eight.

Q. And how about the same question by way of increase as from '88 to '91 for Dr. Raymond Armstrong?
A. Again, the same. The same as the previous figure.

Q. And you said that Dr. Bryan obviously did none in 1991?
A. That's correct.

Q. Who were the top two as of 1991 as doing General

Stark?

A. I have worked with Tina Stark on surgery cases and she is a surgical tech and I don't think that she's a good surgical tech.

Q. Why not?

A. I don't think that she pays attention to the cases and I think that she's slow. And I have found her personally difficult to work with, because she just doesn't have things ready on the spot when you need them. And I find her inattentive.

Q. And I see that this incident report signed by Tina Stark is typed. Does it appear a little unusual one way or another to you?

A. These are both typed? These are both typed.
Q. Yes.

A. I have no idea who typed them.

Q. All right. Now, on to the next one, on the next one, that's the Tina Stark and you have given us your opinion on that. Let's go to the next one. In time I'll do these in chronology. The next one is March the 11th, 1990. And I'll ask Mr. Donahue to pass number 83 for counsel on up to you. Will you please take a look at that. Just scan that because I believe you have reviewed these before. And I think I can summarize this as being a misdirected patient, and

I think.

Q. Now, have you worked with the Complainant, the woman who signed the incident report?

A. Michael Green?

A. Yes.

Q. Again, the same question I asked you about Tina Stark, your impressions about the ability of Michael Green.

A. I did not work with Michael as much as I had worked with Tina, and there are certainly people in the O.R. with whom you develop a rapport right away and others with whom you do not. I didn't think he had a good attitude toward his work and I also felt that he was somewhat inattentive. But that was only on a few occasions. I didn't work with him that often.

Q. Now, just briefly, have you worked with Dr. Gurri?

A. Yes.

Q. Does he perform, in your experience, does he perform the same type of surgery as Dr. Floyd Bryan?

A. I believe so.

Q. Does he perform the serious type of operations or deal with serious sick patients --

A. Yes.

A. No, not with Lynne Stoldt, no.

Q. With whom?

A. I believe Monica Utz (ph).

Q. Do you know a Lynne Stoldt?
A. Yes, I do.

Q. Were you told that you would not be recommended for rehiring by Holmes Regional Medical Center?
A. No, I was not.

Q. You did have an exit interview, didn't you?
A. Yes, I did.

Q. Did you say that you were unhappy and that all aspects, about all aspects of your job, that you came from the military and felt something about too accommodating here, at Holmes?

A. No, I believe in my exit interview, I was asked by Miss Utz to indicate why I was unhappy with the clinical situation, you know, as an operating room nurse at Holmes, and I told her that I'd had some problems with staffing. With the scheduling process, that I felt that we, the patient load was periodically too heavy for the staffing, for the workload. I also had some problems with mid management not being supportive enough with the three to eleven staff. And I believe I would not necessarily agree with what you just read. There was an at-length statement as to why

that I gave in my exit interview why I was unhappy clinically with my job situation at Holmes. And I gave that in confidence in an exit interview.

Q. Well, I have been provided a copy of that.

A. Yes, sir, I know you have.

Q. May I approach the witness, Your Honor? Is this a copy of the exit interview for Michael G. Greene, giving your social security number, last day of employment, July 26, 1990, evaluator, Lynne Stoldt, RN, BS, Assistant Vice-President?

A. That's not the form that I saw when I was making an exit interview, no. I think that was the form that was made out by Ms. Stoldt after the fact.

Q. Would you read this here, publish this? Would you recommend this employee for rehire? What does it say?

A. MR KAY: Object, calls for hearsay. It is not his report, it is another nurse's.

THE COURT: Sustained.

Q. Now, sir, as to your testimony before the Dr. Chanda Panel, who asked you to testify before the Dr. Chanda Panel?

A. I believe I was asked by, it's been so long ago now. I believe I was asked by the hospital attorney, Mr. Storms.

Look at the first page there, Dr. Guy, so that we put all this together. The date of that incident report, looking at the top left-hand corner or about a third up there is dated March 7, 1990; is that correct?

A. Yes.

Q. And if you look at the bottom right corner, the date of the actual incident report signed by Tina Stark and Jane La Casse is dated March 13, 1990.

A. Yes.

Q. A period of six days. Now my first question to you is, is there any rule within the hospital which requires that incident reports be filed within 24 hours of the incident?

A. I'm not sure. I don't know that.

Q. In any event, have you now reviewing this incident report involving Tina Stark and Jane La Casse and of course Dr. Bryan that involved a Fogarty catheter, and we have been through this this morning as far as the Fogarty catheter and things of that nature. Having read what you just read, this is, the incident report of March 7th, 1990, which we'll call the Tina Stark incident report, do you see anything in there which would warrant taking Dr. Bryan off the staff permanently?

A. No.

A. Yes, I did.

Q. Did you also prepare an incident report on Dr. Bryan's behavior against Tina Stark?

A. Yes. At the end of the case Tina and i got together and with the intentions being the circulating nurse normally is the person because they're licensed fills out the appropriate paperwork.

Q. Would that be you?

A. That would be me. And we got together, made sure of the, confirmed the situation and the sequencing and wrote down a draft. Tina wrote the draft as we were both discussing the sequence of the case.

Q. The next day did you give an oral or dictated report?

A. I'm not certain if it was exactly the next day. I do know that the incident report for the leg was turned in that night and the, I turned that in, and Tina turned in the rough draft that night. The following day we were called before our three to eleven shift, Judy Bourne had talked to us and then we all were called to Lynn's office.

Q. And who is Lynn?

A. Lynn Stoldt is the Vice President of Nursing in the operating room.

Q. And did you give a more detailed report after your meeting with Lynn Stoldt?

A. Yes. Lynn asked us to each tape an incident report and a sequence of events as best as we could understand.

Q. Did you tape that report in a room by yourself?

A. Yes, yes, we both did.

Q. And then was that report typed up?

A. Yes, it was.

Q. Now, there's been, handing you what has been marked as Exhibit Eighty Two, is that in fact your report as you dictated it?
A. The second page that starts with the report prepared by myself, yes, that's it. That's mine.

Q. And in that report do you reflect as you testified today that Dr. Bryan made the statement, the patient is bleeding because you did it wrong?
A. Yes.

Q. After Tina had said don't you hit me?
A. Tina said don't you hit me, yes.

Q. And your report also reflects that he, as you've testified, I want it this way every single time, leaning over looking over at Tina over his loops and asking Tina the question three different times, each time his voice getting deeper, don't you?

A. That's correct.

Q. By the way you also indicate it's very frustrating to work with him when he was not in control. At that point in time do you feel that Dr. Bryan was displaying evidence that he was not in control?

A. Yes, I do.

Q. Now, there's been some question about this document reflecting that the incident occurred on 3-7-1990, but looking at the first page it indicates that the date of it is 3-13-90. Could you tell the jury, I believe the event occurred on 3-7. When did you get an opportunity to review that which you had dictated in a typed form?

A. It was sometime the following week. There was a weekend involved from what I can remember and I believe that the tape report was done on Thursday, I can't remember exactly if it was Thursday. I do know that the tape recorder stayed in Judy Bourne's office over the weekend and there was someone that was supposed to type the report.

Q. Judy Bourne or Lynn Stoldt?

A. It was in Judy Bourne's office where we left the tape.

Q. And then after the tape was transcribed, did

they provide a copy for you to read?

A. This copy, yes, was the primary copy. We read and then we were asked to sign.

Q. But when you dictated this occurred shortly after the event?

A. Yes, it did.

Q. Now, you had indicated that you had prepared something the evening before. Was it your idea to prepare an incident report?

A. Most assuredly.

Q. Did anybody in the Hospital tell you to prepare the incident report?
A. No.

Q. Excuse me. Go ahead.
A. I'm sorry for interrupting. That is, again, a standard of practice that a registered nurse, a circulating nurse would do for any unusual occurrence in the room would be to write an incident report. It is also Hospital policy.

Q. Why did you believe an incident report should be filed here?
A. I believe a slap is most definitely an unusual occurrence.

Q. Have you, did you believe this was an inappropriate and abusive behavior on the part of Dr.

MR. KAY: Your Honor, again objection. May I approach?

MR. METZGER: Your Honor, I'll withdraw the question.

MR. KAY: I'd like to approach, if I may.

THE COURT: He withdrew the question. No reason to approach.

MR. KAY: Your Honor, I just request sidebar at this point.

THE COURT: There's no record.
MR. KAY: Okay.

BY MR METZGER:
Q. When did you review this statement of March 28, 1990 by Gene Gonyaw?
A. This was supplied with the incident report.

Q. All right. Let's just go through the chronology now. This event, alleged event occurred on what date?
A. March 7, 1990.

Q. March 7, 1990. And you filed your incident report six days later, that is, the typed incident report on the 13th, correct?
A. No, sir. I would like you to re-ask the question and I did not supply my incident report at that later date. I filled out the incident report about the leg falling off the table the night of the occurrence and

We also had, Tina and I had filled out a preliminary report that night and turned both of those in the night of the occurrence.

Q. I'm looking at the incident report. Do you have the incident report in front of you of March 13, 1990?

A. Yes, I do.

Q. And so that we're all looking at the same thing, does that have a number on it?

A. The very first copy says Exhibit number eighty two.

Q. Thank you. Now, referring to Exhibit number eighty two, would you just look at the first page and tell us the date that Tina Stark, O.R.T., and Jane LaCasse, R.N., signed this incident report? Isn't it March 13, 1990?

A. I would say not necessarily true, sir. And the reason I say that is we signed it but we did not date it. We did sign, in fact.

Q. Well, doesn't the first page show that this document, this incident report of this alleged incident was signed by you and Tina Stark on the 13th day of March, 1990? Yes or no?
A. No.

Q. When was it signed?
A. I can't tell you the exact date. I can tell you

that yes, it was signed, and I can only refer to the date that it was, the date that's at the bottom that it was typed.

Q. All right. Let's just run through this now. You said you signed, you prepared -- first of all, when you heard this alleged slap you picked up a piece of paper and a pen and you started to write in the operating room?

A. Yes, sir.

Q. And the operation was going on?

A. Yes, it was. And that's why I picked up the pen and paper.

Q. And you were the circulating nurse for this patient?
A. Oh, yes.

Q. This was an aneurism?
A. False aneurism of the right groin.

Q. That can be fatal, can't it?
A. No, it cannot be. An abdominal aortic aneurism can, but a femoral aneurism, not fatal.

Q. Not fatal. Well, what if it bursts?

MR. KAY: Objection, Your Honor. there is no evidence to this in the record.

THE COURT: Overruled.

Q. What if this aneurism which is already gone into

format, and often times we write down an anecdotal note form and that was what we did. That's what we're calling our rough draft or our preliminary, that was the anecdotal note format.

Q. Had you ever done a preliminary draft before?

A. I have on other occasions.

Q. And what did you do with this preliminary draft or this anecdotal thing?
A. Tina turned it in.

Q. To whom?

A. We both put it in a signed box where we we're supposed to turn in incident reports. She turned in that report and I turned in the one that I had completed on the leg having fallen off the table.

Q. So there were two incident reports, one about the leg falling off the table and one about the alleged slapping?
A. Yes.

Q. And you just put them in a box?
A. In a slot like mail box, a signed mail box, yes.

Q. And to whom, what person was that directed?
A. That generally is reviewed by Judy Bourne who is the Nurse Manager, and then from there often times they're also reviewed by Lynn Stoldt, the Vice President of Nursing in the operating room.

Q. Do you know by whom it was in fact reviewed, the preliminary or the anecdotal report?

A. To the best of my understanding Judy Bourne had read it the following day, and when Tina and I came in to our three to eleven shift she had directed us to go to Lynn Stoldt.

Q. And then you went to Lynn Stoldt and according to my notes you then took a tape recorder and then you did another incident report which you dictated?

A. Yes. Lynn asked us to dictate, for each one of us to individually dictate a report.

Q. All right. And what you dictated is what we have here in front of you, this three page typed report by Jane LaCasse which is attached to the incident report dated March 13, 1990, correct?
A. Yes.

Q. Who typed this?
A. That I don't know.

Q. What happened to the one you wrote out?
A. I didn't write it, per se. Tina was writing it.

Q. I thought there were two, one that you wrote and --
A. The one that I wrote was turned in, and when we talked to Lynn the following day I did in fact see her with it because she asked me about that as well.

Q. Now, do you have your typed report which is dated, which you signed apparently on March 13 or sometime before, on or before March 13, 1990? Do you have that in front of you?

A. Yes, I do.

Q. As number eighty two?
A. Yes.

MR. KAY: Objection to mischaracterization regarding her prior testimony.
THE COURT: Overruled.

Q. All right. Would you just please help me as we go through this? Do you have page one there?
A. Yes, I do.

Q. And just so we're all on the same one, it's three pages, isn't it?
A. Yes, it is.

Q. And the last page has Jane LaCasse, R.N., and it has your signature, doesn't it?
A. Yes, it does.

Q. And on the front page it also has your signature, doesn't it, one dated 3-13-90?
A. On the official incident report form, yes.

Q. All right. Now, to your three page typed report. If you'll just follow with me, I have a few questions. You say Tina Stark was the scrub nurse and

Do you have a copy of that?

MR. KAY: No, I don't believe it's ever been requested. Not in this case. Doesn't involve Dr. Bryan's behavior.

Q. Now, have you reviewed the typed report prepared by Tina Stark?

A. Yes, I have.

Q. What's the date of it?

A. Incident involving Dr. F. Bryan on 3-7, 1990.

Q. And on the first page, Tina Stark signs this on March 13, 1990; correct?

A. Again, sir, I'm not certain that we signed it on the 13th. I know we signed it, I don't know when.

Q. All right. Do you have that in front of you, her report?
A. Yes, I do.

Q. Just a few questions on that. Now, the middle of the page, and this is approximately 20 lines down, it says, and I'll be happy to point this out to you. It's about halfway down, Mrs. LaCasse. It says the Fogarty catheters were lying on the back table. Do you see that?
A. Uh-huh.

Q. And Lee before she left -- are we referring to the one and the same Lee Dunham?

A. If I had the operative record in front of me, I would be able to tell you more accurately. I believe that I recall the incision was at 5:02. I know I took the patient to recovery room at 5:50. I cannot recall exactly the closing time of the case. It was somewhere between 5:40, 5:45. But again, unless I have the operative record in front of me, I don't remember when it finished.

Q. Well, we haven't been supplied that, so we'll just have to go on your memory. That's your best recollection; correct?

A. Yes.

Q. Now moving on, you did tell us that you testified under oath before that Dr. Joseph Chanda Panel; is that correct?

A. Yes, I did.

Q. Do you recall the date you testified?

A. No, I don't. I know the month was August. And the year was 1990. I don't recall the date.

Q. All right. Now when you gave the tape report which then was to be typed, you gave it because you were unsure how to report it accurately, in an accurate way?

A. I wanted to be sure that the sequence of events were accurate and Lynne asked us to tape the report.

As she was reading our preliminary report, she felt that we may not have had all the sequence of events and she wanted us to be accurate. So she did ask us to tape the report so that we could individually recollect the entire case as much as possible.

Q. When you gave the typed report, were you unsure how to report it accurately?

A. It was unnerving to have had a nurse slapped and therefore there was a lot more emotion, emotion on my part attached to this unusual occurrence.

Q. Yes, Ma'am, but my question was, when you gave the typed report, were you unsure how to report the alleged event accurately?

A. No.

Q. Page 250, Chanda Panel, under oath, August 8, 1990, Line 7, Question, can you relate to the Committee how it happened that the incident occurred on the 7th and the report was not signed until the 13th? Answer, your answer, we gave a taped report, being unsure how to report it accurately. Both Tina and I and we had collaborated to make sure that we were saying, what we were saying was to the best of our knowledge accurate. I did in fact make an additional report that evening to cover possible injury to the patient's leg.

Was that your answer at that time on August 8th?

A. It sounds like it. If I had a copy of the Chanda Hearing in front of me, I'd be more than glad to read along with you.

Q. Incidentally, where did you read the Chanda transcripts?

A. They were mailed to me within this last week.

Q. So you had plenty of time to read it?

A. I'm sure they could be said that way.

Q. Now, was there any injury, bruise, mark, discoloration, bleeding involving the hand of Tina Stark after this was all over?

A. I don't know, sir. I didn't look. I don't know.

Q. You didn't look. It wouldn't be important one way or the other? Correct?
A. To her it would be important and I'm sure she followed through because it happened to her.

Q. Did she have any injury that you're aware of?
A. I have no way of knowing.

Q. Well, when you taped the report the next day, she wasn't wearing gloves, was she?
A. I didn't look at her hands.

Q. Now was this a small case?

come off the table. So we were, we just sat down at the table and wrote them out. That's basically it.

Q. The next day when you came in, did you meet with anybody regarding the incident?

A. Yes, I met with Lynne Stoldt, who is our, I guess her title would be Assistant Vice-President of Nursing. I think that's correct. And she recommended at that time that since I was, I was very upset and very adamant about this is not acceptable behavior, that she suggested at that time that I, that I give a report over, she had a small recorder, and I didn't have a chance, that would have been Thursday, I didn't have a chance at that time to do it because we were real busy. And she says, well, you can just do it the next day. So I did it Friday.

Q. When you gave this report into the dictation equipment, was anyone else in the room?

A. No, no one else was present.

Q. You said that you were upset. Did you express anger or upset, the fact you were upset to Lynne Stoldt?

A. Yes.

Q. And why were you upset?

A. I had never, I had never, this has never happened to me before and I, I didn't quite know how

Q. All right, now, the incident report that you have there in front of you, what's the date of it on the first page?

A. Are you relating to Gene's incident report or my own?

Q. No, I'm sorry, I apologize. I mean to ask you, what is the date of your incident report, the first page when you signed it?

A. It says on the front page, report prepared by Tina Stark, ORT, regarding incident involving Dr. Bryan on 3-7-90.

Q. What's the day you signed it? Look on the bottom right corner. First page.

A. There is nothing on there, sir.

Q. The first page.

A. That is the first page.

Q. The first page on the incident report.

A. Down here, 3-13-90.

Q. Can you explain why you signed this incident report on 3-13-90 when the incident occurred back on March the 7th, '90? That is a difference or an interval of six days from March 7, 1990 until this incident report of March 13, 1990.

A. Well, this is the, this would have been that typed one we talked about earlier. And I was asked to

give it on a dictaphone and I believe, March 7th was a Wednesday, the 8th would have been Thursday. I gave, my dictation would have been on the 9th, which would have been Friday. And that means, and I didn't do it till my regular scheduled shift, which is in the afternoon. I don't believe I did it until like six or seven at night. So it sat in the drawer all weekend. So that would have been the 10th and the 11th would have been Saturday and Sunday. The 12th would have been Monday and that was probably when it was typed up. And then it was typed up Monday, I didn't see it probably until either Monday or Tuesday.

Q. Now, after this alleged event occurred on March 7th, 1990, did you and Jane LaCasse discuss it?

A. The event itself?

Q. Yes.

A. Probably the only discussion occurred while we jointly were making out the incident reports, which would have been that evening on March 7th.

Q. So then both of you prepared handwritten incident reports on March 7th, 1990?
A. Yes.

Q. And what did you do with your handwritten incident report of March 7, 1990?
A. I put it in, we have these outside of the O.R.

Q. All right. At that point to your knowledge had an incident report been filed?

A. Not to my knowledge.

Q. All right. Was anything said to you about Mr. Greene about being hit or struck with a suction device?

A. Yes.

MR. KAY: Objection. Calls for hearsay.

MR. MOSS: Okay.

THE WITNESS: Yes. He mentioned the fact that Dr. Bryan had rapped him on the knuckles or the hand.

BY MR. MOSS:

Q. Okay. And how did he characterize that to you?

A. He characterized it to me as it was no big deal.

Q. At some point later were you aware that he wrote an incident report?

A. Yes, I was so informed.

Q. Okay. And when did you learn that?

A. About a week later, I believe it was.

Q. And then since that time did you talk with Mr. Greene about the reason that he wrote up an incident report?

A. No, I didn't.

Q. Now, do you have an opinion, based on being an operating room person, a nurse in the operating room since 1978, have you become aware as to whether there is an

The system was flawed?

A. I don't think any of them were false in that somebody just made up a story. I think some of them you couldn't verify, some of them nobody knew anything about. Some of them were frivolous. Some were frankly silly. But the system was so fouled up that nobody could tell anything about a lot of them.

Q. So the Executive Committee, Defendant's Exhibit 104, the Minutes of June 12, voted to instead of no punishment, give you what?

A. Two weeks punishment.

Q. Did we appeal?

A. Yes, sir.

Q. Did you appear before the Board of Trustees with me?

A. Yes, sir, I was there to answer questions, I wanted to be there to answer.

Q. There was no transcript of the proceeding?

A. No, sir.

Q. Did I make the same arguments that I have made here today, that you hadn't been contacted and you didn't have the ability to respond to the charges, that the Ryon Panel found that the incident report system was flawed, all of those, did I go over that with the Board of Trustees?

MR. MOSS: Would you finish that?

Q. And then as amplified by that question, all right, that, I have got several series of questions. He's going to another line.

MR. MOSS: Well, I'll do it later.

Q. Do you recall that testimony being given before the Chanda Panel?

A. Yes sir, I recall him saying that they thought the incidents occurred. And nobody's ever denied that. The question is, are you making a mountain out of a molehill? Were they blown all out of proportion? That's the question.

Q. Then did you appear before the Executive, excuse me, before the Board of Directors?

A. When?

Q. In October of 1989. October 19, 1989, after the Ryon Panel.

A. After the Ryon Panel, yes, I went before the Board of Directors to answer any, at my request, to answer any possible questions they might have.

Q. And did they at that time indicate to you that they agreed with the Medical Executive Committee that you were guilty of disruptive and unprofessional behavior?

A. October?

The receiver is ultrasensitive, you could make a tiny sound and it picks it up. If you see what I mean.

Q. But now you have already admitted that you had a loud voice and lost your temper; isn't that correct?

A. Yes, sir, that's true.

Q. So you're not talking about a situation where you're just a little tiny voice here in the wilderness, are you, sir?

A. Absolutely not. But what I's saying is the tone of voice I could use to you or Mr. Moss or anybody else, if I, might be perceived as somebody else as being loud and overbearing or something.

Q. Well, you certainly haven't been loud or overbearing in this courtroom, have you, sir?

A. I have tried very hard not to.

Q. In fact, you have acted very differently here than you have in the operating room on occasion?

A. No, sir, I don't think so. I'm sorry, you said on occasion?

Q. Yes, sir.

A. On occasion in the operating room, I have been loud. On occasion in the operating room you have to wake people up, to get them to move. They're just not with the program, they're not paying attention, wandering in the halls, talking on the telephone, and

you know, you have to do something to get their attention.

Q. Well, I believe in response to questions yesterday from Mr. Moss, you indicated that you wouldn't be here today if you treated the people that worked with you in the hospital with the same respect you treated this jury?

A. I don't think that's a global situation, I don't think. There were instances when I was loud to nurses, there were incidents when I said sarcastic things to nurses. I think that I offended people, some people. I don't think it was ever directed at the person, I think it was always directed when a patient was -- the only time it upset me is if somebody was doing something and the patient wasn't cared for.

Q. But you're also trying to do it in such a way because you learned that if you insult nurses, you won't have to work with them again?

A. No, I don't think so. I think, I don't think I tried to do that at all. I think I was trying to give good care to patients.

I believe you said that you thought that there was a recommendation from medical supervisors or nursing supervisors that they document or write up Dr. Bryan.

A. Uh-huh.

Q. Is that a yes?
A. Yes. Yes, I'm sorry.

Q. And would you tell the jury why -- First of all, how do you know that and what do you mean by it?
A. It was recommended or it was suggested that in all incidences that required a conflict, that they would be documented. And it was strongly recommended that they do it that day.

Q. All right. When did that occur in relation to Dr. Bryan's suspension?
A. Oh, I have no idea when. You mean when it was suggested?

Q. Was it the year before or within a short time before his troubles, if you will?
A. Yes. I would say probably -- When I was aware of it, when I had heard it had been stated was about a year before. A year before the suspension.

Q. Were you aware of physicians other than surgeons that were, quote, out to get Dr. Bryan?
A. Physicians other than surgeons? No.

Q. Okay. Specifically, were you aware that Dr.

Bryan was in disfavor with either anesthesia or with Dr. Mills?

A. I don't know about Dr. Mills. I know that there were some anesthesia people who were not on his hit list or favorite list of the month.

Q. Okay. Were you made aware as to whether there existed any desire to get rid of Dr. Bryan by any people, that is, get rid of him from the staff?

A. Who would say this? Anybody?

Q. Anybody.

A. As I mentioned to Mr. Kay, it was an opinion that I formed from miscellaneous information. Now, whether it was spoken to me or I overheard it, it's very difficult for me to pinpoint, and that's why I hesitate to say. But yes, my opinion was that there were certain members on staff who would prefer that Dr. Bryan not be on staff.

Q. And this opinion was formed from conversations that you overheard or conversations that you engaged with nurses and other doctors.

A. Yes.

Q. Over a period of years?
A. Of years.

Q. Do you know why?
A. Why they would -- No. Anything that I say would be my own opinion.

MR. KAY: Object to the form.

BY MR. METZGER:

Q. Doctor, you were asked questions by various members of the panel, and I'm looking specifically at page 244, where Dr. Chanda asked you a question where he asked you, quoting: "Let me ask you one quick question. At the outset I believe you either offered the information spontaneously or in response to a question you thought there was either an effort or a conspiracy to get Dr. Bryan off the staff," and you said yes. Was that a correct answer?

MR. KAY: Object to the form of the question.

THE WITNESS: Yes.

MR. KAY: No proper foundation.

BY MR. METZGER:

Q. What did you mean by that, sir?

A. Well, I actually answered it earlier. I'm assuming that because there was a hearing that the hearing was directed toward moving in a way to get him off the staff. I thought that the reason we were all there, in fact, was to come to some kind of decision about removing him from the staff. I thought it was pretty obvious.

Q. All right, sir. Now, at page 246 -- and I just wanted to ask you about your answer at page 246 -- where you said: "Yes. Without mentioning names through two days or

that frequency?

A. Uh-huh.

Q. By multiple physicians?

A. By more than one.

DR. CHANDA: Okay.

MR. MOSS: Are you implying that someone is trying to get Dr. Bryan thrown off the staff?

THE WITNESS: Yes.

BY DR. HALLSTRAND:

Q. Libby, how many doctors would you say total?

A. That are what?

Q. That you feel fall into the category Dr. Chanda just asked you about?

A. Three.

Q. Okay. And what is the total number of physicians that you think interact in the operating room who might have an opinion?

A. Who might have an opinion regarding --

Q. Well, in other words, people who would be around who, if exposed to those comments of Dr. Bryan's behavior, good or bad?

A. Extensive, uh-huh.

Q. Are we talking, you know, in hundreds or twenties or, you know, how many doctors do you think that

on Dr. Bryan?

A. No.

Q. Do you know of any instance where administration has asked you to fill out an incident report on any physician?

A. No.

Q. Do you know of any instance where administration has asked other nurses to fill out incident reports on other physicians?

A. No.

Q. Therefore, do you know of any instances where administration has asked you or other nurses to fill out incident reports against Dr. Bryan?

A. No.

Q. Have any of your superiors among the nursing staff instructed you to fill out any incident reports against other physicians?

A. No.

Q. Do you know if any superiors on the nursing staff have instructed other nurses to fill out incident reports under physicians?

A. Yes.

Q. All right. Do you know of instances where those members of nurse administration have directed nurses to fill out incident reports on Dr. Bryan?

A. Instructed the staff to do so?

Q. Yes.
A. I wouldn't say instructed. I would say recommended.

Q. Do you know of any instance where the nursing administration has instructed nurses to prepare incident reports on other physicians?
A. No.

Q. Do you know of other -- of any instances where the nursing administration has instructed nurses to -- or recommended nurses, excuse me, to prepare incident reports on other physicians?
A. Yes.

Q. All right. So is it your testimony then that the nurse administration has recommended that nurses in the past fill out incident reports on several different physicians at Holmes, including Dr. Bryan?

A. Not several, no.

Q. How many?
A. Two.

Q. All right. Who are those?
A. Dr. Paine and Dr. Bryan.

Q. Okay. To your knowledge, have the nurses prepared those incident reports on --
A. Yes.

out the incident and document it.

Q. Did --

A. Now, you must remember, I am not an incident report person. I make out probably the least amount. There are some people whose personalities encourage them to make out incident reports over everything so you have to weigh who it is doing it. You understand what I'm saying?

Q. Yes, ma'am.

A. Okay.

Q. Have you prepared incident reports in the past?

A. Yes, uh-huh.

Q. Is that based upon what you believe is right or based upon the recommendation of your nursing supervisor?

A. Well, it's based on, one, what is required of the hospital policy; and then two, if it happened to me as an individual.

Q. Okay. Now, you talked about a situation where you were aware that a nursing administrative person had made a recommendation to a nurse to prepare an incident report regarding Dr. Bryan.

A. To document it, right.

Q. How many times do you know that happened?

A. I only know of one.

Q. Okay. And who was that nurse administrator?

A. I knew it. I knew you were going to ask me.

that to him? And he said for the heck of it. He touched me too, I can sue him.

Is that the truth?

A. That's the truth.

Q. And have you ever been encouraged or do you know that there's people on the staff that encourage people to write up Dr. Bryan?

A. Um-hum.

Q. Has that been going on for about three years?

A. Um-hum.

Q. Is Dr. Bryan treated differently than other surgeons?

A. Yeah, I would say.

Q. How?

A. Well, he's written up more. I heard a statement made by a particular anesthesia doctor that if -- which I'd rather not, you know, say his name, but I was told that, you know, if Dr. Bryan does anything, no matter what it is, you write him up 'cuz we got to get him out of here.

Q. Do you have an opinion about the suspension of Dr. Bryan and what's been going on?

A. Well, yeah, of course I do. I think that --

MR. STORMS: Mr. Lovering, I would object to any opinions that might be rendered by the witness. I think that that's the

out of the ordinary occurred, either to a patient or to a staff person.

Q. Okay. Now back at the beginning I asked you about whether Dr Bryan had been singled out or treated differently. Are you aware of any different treatment with Dr. Bryan concerning incident reports?

A. Am I personally aware of it? No, I'm not.

Q. Okay. Have you heard of instances within the operating room which evidence that he was being treated differently from other people?

MR. KAY: Object to the form of the question.

BY MR. MOSS:

Q. Let me withdraw it and ask it this way. Have you seen instances where Dr. Bryan has been written up where other physicians who have done the same thing wouldn't have been written up?

A. Yes, I have.

Q. Tell the jury about that, please, ma'am.

A. Incidence reports are a very personal type thing. If it's a physician that you are friendly with, that you have good rapport with, you will go that extra mile. If it's a physician in which you have strained terms, you are, as human beings, more tempted to write up that situation.

Q. Okay. As it relates to your own personal

experience --

MR. KAY: Let me just if I may, excuse me.

MR. MOSS: Sure, go ahead.

MR. KAY: Just move to strike that last answer as nonresponsive. Thank you.

BY MR. MOSS:

Q. As it relates to your personal experience, Ms. Ayers, would you characterize Dr. Bryan as being a disruptive person in the operating room? And you've been there.

A. No.

Q. Does Dr. Bryan have a temper?

A. Yes, he does.

Q. Do other physicians currently on the medical staff have a temper?

A. Yes, they do.

Q. Can you characterize Dr. Bryan's temper or aggressive behavior, whatever you'd like to call it, in relation to the other surgeons with whom you work?

A. I would say probably one-third of the surgeons or maybe a little less, have the same temperament as Dr. Bryan.

Q. So a little less than one-third of all the doctors that perform surgery at Holmes have some sort of

temper?

A. Yes.

Q. Has Dr. Bryan' temper or temperament changed in the period of time that you've been working with him?

A. Yes, it has.

Q. How has it changed?
A. He's become more mellow.

Q. Okay. When did that change occur?
A. Oh, I don't know. Several years ago.

Q. Okay. Are you aware that Dr. Bryan has been permanently suspended from staff privileges at Holmes Regional Medical Center?
A. Yes, I am.

Q. Did you testify at some of the hearings that occurred earlier?
A. Yes, I did.

Q. I gave you a copy of the transcript of the testimony. Have you reviewed that part today?
A. Yes, I have.

Q. As I understand it, you have quite a feeling of loyalty or a warm feeling in your heart for Holmes Regional Medical Center.
A. Yes, I do.

MR. KAY: Object to the form of the question.

Of those doctors who presently practice general surgery at Holmes Regional Medical Center, where is Dr. Bryan when you last worked with him, which I guess would be in 1990, '91 -- '90 -- where is he on the behavior scale, the temper scale, if you will?

MR. KAY: Object to the form of the question.

THE WITNESS: As what, one to ten or --

BY MR. MOSS:

Q. However you like to do it.

A. Well, temper is a subjective type thing. Every day Dr. Bryan didn't come in showing his temper and every day he didn't come in showing -- telling jokes and laughing. It would -- The times that I have seen him exhibit temperament has been directly associated with an incident that was ongoing.

Q. And would it be where something was not working properly or going smoothly about an operation?

A. Exactly.

Q. All right. Now, my question had to do with Dr. Bryan in the constellation of surgeons there, where would he fit within the picture? Was he worse than any of them?

A. No.

MR. KAY: Objection. Excuse me. Go ahead. It's the same objection I had

Q. Now, Dr. Foley, who is the medical director of the hospital, is the same Dr. Foley that you have told counsel for the hospital would push your hand aside with a retractor?

A. Uh-huh.

Q. That's a yes?.

A. Yes, yes, I'm sorry. Yes.

Q. And the same one that yelled at you?

A. Yes.

Q. And had a temper?
A. Yes.

Q. And yet he has been made the director of medicine at the hospital and not suspended?
A. Right.

Q. To your knowledge, did either Sarnowski or any of the other doctors, they were all good surgeons, too?
A. Yes.
Q. Did they ever lose their staff privileges?
A. No.
Q. Dr. Armstrong and Dr. Gurri and Dr. Foley, in your opinion as a member of the hospital operating room suite, are the powerful politically?
A. Yes.
MR. KAY: Objection.

BY MR. MOSS:

A. I can't speak for them.

Q. Well, have you had occasion to observe people who when working with Dr. Bryan became so tense that they actually broke out in tears?

A. Not when I've been in the room, no.

Q. Have you heard about that?

A. I can't think of any one particular incident. No, I can't think of anyone that comes to mind who's broken down in tears. I've broken down in another doctor's room, though --

Q. Isn't it true, Becky, in the OR suite that a lot of gals up there say I can take him for a couple of days but give me a break? I'm talking about Dr. Bryan. Give me a break and assign me someone else? Isn't that the case?

A. Yeah, but he's not the only one, though, Mr. Storms. Okay? We all need a break -- After you've worked with somebody for many, many days, you got to have a break.

Q. You're saying that he's not different than anyone else? Is that what you're saying?

A. No, he's not.

Q. He doesn't have a reputation in this hospital for being difficult to work with, being disruptive?

A. I don't think being difficult to work with, no.

Q. Doesn't have that reputation?

A. And he's not disruptive. I don't think he

does. Not any more so than any other doctors, though. He's not any different.

Q. How about -- Strike that.

MR. STORMS: That's all. Thank you, ma'am.

HEARING OFFICER LOVERING: Any questions?

(No response.)

HEARING OFFICER LOVERING: Then this witness may be excused. Thank you.

(Whereupon the witness was excused.)

(Whereupon a recess was taken.)

SANDRA MILLER,

the witness herein, after being duly sworn, did testify upon her oath as follows:

MR. MOSS: I will say this, and this is an apology to Mrs. Miller, that she's going to testify essentially to the fact that he's been singled out which has been testified to, that people have encouraged her to file incident reports against him; that his temperament has gotten better; and about the slapping or hitting not being unusual and that he's a good doctor. And I think I've characterized what you're going to say.

hands if you're in the way?

A. Yes.

Q. Have you been struck with, or tapped with instruments when your hand's in the way and the doctor's looking for some particular area?

A. I have had it moved with instrument before.

Q. Can you characterize Dr. Bryan as it relates to the total spectrum of surgeons that operate with you at Holmes Regional Medical Center or that did back in 1990, as it relates to his temper or his aggressive behavior?

A. They're all different temperaments. Some are very laid back and some have temperaments and ranking the ones with those that have temperaments, I would have to say he was fairly equal.

Q. Equal; Was he the worst man in the operating room?

A. No.

MR. MOSS: Thank you, that's all I have.

CROSS EXAMINATION

BY MR. SCHIRTZER:

Q. Good afternoon, Miss La Pointe. My name is Ron Schirtzer and I'm counsel for Holmes Regional Medical Center. And each of the individual doctors have been sued by Dr. Bryan in this case. I'm going to point

A. We were doing an aneurysm and I went in and automatically cathed the male patient, which was something that he never wanted the nurses to do. That was something he always wanted to do.

Q. And did he let you know that he was displeased?
A. Yes, he did.

Q. And did you have a conversation with him about that?

A. Yes, we did. We had a conversation afterwards and I apologized, I told him that I knew it was my fault, that I had messed up, that I would not do it again.

Q. Did he hold a grudge against you after that?

A. No.

Q. Did he continue to argue with you or anything after that one period of time?

A. I never had any problems with him after that.

Q. In other words, you'd made a mistake and it made him mad?

A. I had made the mistake, it was my fault, it made him angry. But we talked about it between ourselves, solved a problem, and I, you know, never had any trouble since.

Q. Have you ever refused to operate with him?

A. Never.

Q. When he got angry at you, did it make you so upset that you couldn't continue to function?

A. No.

Q. What type of surgery does Dr. Bryan do?

A. Dr. Bryan was a general surgeon, also a cardiovascular surgeon.

Q. Can you tell the jury about cardiovascular surgery?

A. Cardiovascular surgery is similar or is like when a patient had an aneurysm in the main blood vessel, going from the heart to the rest of the body, will rupture, bleed, or they can also have to have vein grafts in their legs due to their veins clotting off. Very tense surgery, especially when you're doing the big abdominal cases with the main aorta, it can be very tense, very hot moments in there. Everybody loses their temper.

Q. Do you get excited and nervous and stressed out in these operations?

A. Yes.

Q. Do doctors performing vascular surgery other than Dr. Bryan react when something goes wrong?

A. Yes, they do.

Q. How do they react?
A. A lot of them get angry. They're not in control

to have certain nurses in their rooms.

Q. Why does that happen? I thought everyone was supposed to get along in the operating rooms?

MR. SCHIRTZER: Objection, speculation.

THE COURT: Overruled.

Q. If she knows. You may answer.
A. Personalities.

Q. Now, as it relates to personalities, could you rate Dr. Bryan as it relates to his temper, as it relates to the other surgeons back in 1990?
A. I don't really understand how you mean.

Q. All right. Are there some surgeons that absolutely never have, never get angry?
A. Yeah, there are a few that never get angry.

Q. And is that a great statistical part, a great percentage of the surgeons, or a small percentage?
A. I'd say that's a small percentage.

Q. Would it be fair to say then that the majority of surgeons have some temper?
A. Yes, they do.
Q. Of those surgeons that have a temper, how would you rate Dr. Bryan? Is he the worst one there?
A. No, I don't think so. I think most of them are pretty much even quo.
Q. Even those that continue to practice at Holmes

Q. In your presence, has he ever become angry or mean, violent?

A. No.

Q. As it relates to surgeons, how many different surgeons do you think you have worked with?

A. Different types of surgeons? Or different people?

Q. Different people.

A. Hundreds.

Q. And in the six years that you worked with Dr. Bryan, did you, were you able to form an opinion about him as it relates to how he treated the nurses as compared to the other surgeons?

A. Yes.

Q. And would you tell the jury, please, ma'am, what your opinion of Dr. Bryan is as it relates to his ability to work with the people at Holmes Regional Medical Center.

A. I found him no different than any of the other surgeons that I worked with in the past. And I worked at several different hospitals in different parts of the country. If you knew what you were doing and were competent in your job, I felt like he had no problems with you. As any other surgeon would.

Q. Was he pleasant to you, polite?

A. Yes, always.

Q. And has he treated you with respect?
A Yes.

Q. Have you been with him in times when something has gone wrong with an operation, a bleeding or untoward event happen?
A. Yes.

Q. Does he become more excited?
A. I would say the -- yes, I'll say yes, he becomes more excited.

Q. And is that traditional or is that usual with other surgeons when things start going south, I guess is the expression?
A. Definitely.

Q. In those situations -- I have been south all my life ---- anyway. When things are not going well, has that been true with other surgeons?
A. That they become excitable?

Q. Yes.
A. Yes.

Q. Do tensions rise?
A. Exactly.

Q And when that happens with Dr. Bryan, have you seen him ever hit, scream, yell, stomp or do anything unprofessional?

A. No.

Q. Do you have an opinion based on your experience and being in the operating room as to whether he renders satisfactory and good medical care to the patients with which he was exposed?

A. Yes, I think he's an excellent surgeon. I think that he cares about his patients and that he wants the best for his patients. If something is going wrong or going south, he, I have never heard him -- he has never personally attacked me. If the patient's in trouble, he just wants the best for the patient. He wants everybody to act as a team and he is just very compassionate I think.

Q. And as far as your firsthand recollection, not what others might have said or hearsay or anything like that, have you had any problems with Dr. Bryan throughout your entire career before he left?

A. No.

Q. Let me ask you to assume hypothetically that he's been charged with being a disruptive influence at the hospital. Assume that for me. That he was disruptive and that's why he was let go. And in the two years and some months since Dr. Bryan has left the hospital, have you noticed any change in the way the smooth operation of the hospital is going?

A. No.

Q. Things haven't gotten a lot better? Are the nurses skipping and singing in the halls now?

A. No. I don't notice any change in the atmosphere.

MR. MOSS: Thank you, your witness.

CROSS-EXAMINATION

BY MR. SCHIRTZER:

Q. Good afternoon, Miss Fabian. What area of the, what area of surgery do you primarily work in at this point?
A. Orthopedics.

Q. And you have been doing that since 19 -- how long have you been doing that?
A. '88, '89. I don't remember.

Q. And from 1984 to 1985, you worked on I believe the open-heart unit?
A. Yes.

Q. And is that pretty much an exclusive assignment in terms of dealing mostly with open-heart surgeries?
A. When we started the program, we didn't have as many cases as they do now, so it wasn't as exclusive as it is now. We did do other cases.

Q. In a week, how many other cases would you do?
A. Maybe four.

Q. Have you ever struck a nurse with a metal tonsil tip?

A. I know I've brushed nurses' hands away, and by brushed, that's a very generous term. I know I slap nurses hands away when they're about to undo what I had taken an hour to do. And once again what I was doing was not life or limb threatening. I suspect if it was limb or life threatening, I may be more aggressive if I thought it would save the day.

MR. KAY: Just a moment, please. I have no further questions.

REDIRECT EXAMINATION
BY MR. METZGER:

Q. Just a few. Surgeons turned you down for this dying lady?

A. Yes.

Q. How did you feel?

A. Well, I mean it was a very desperate situation I don't have the expertise, and I didn't have the expertise that Dr. Bryan had at that time or any of the general surgeons. I could probably muddle through it and end up doing some damage, but it was a very desperate feeling, you know.

Q. And how long was Dr. Bryan with you trying to save the lady?

BY MR. FARRELL:

Q. Dr. Levitt, is what has been marked as Exhibit Number 2 for identification one of the incident reports that you referred to as having seen today for the first time?

A. Yes, sir.

Q. And did you formulate an opinion based upon your review of that incident report?

A. I think I would have called the doctor and asked him what went on. I would have found out what the other side of this issue was. Because I, this is the only one of the four that I wouldn't have thrown in the waste basket. But I didn't have the opportunity to do that.

Q. If you were to assume the allegations contained therein by the nurse that Dr. Bryan did, in fact, slap the nurse's hand, do you have an opinion as to whether or not that would be appropriate within the standard of care of rendering services in an operating room?

A. Yes, sometimes it's necessary if there's something that the nurse is going to do, misstep and you're not sure that a verbal command is going to do it, you have to push her away.

Q. And do you have any facts, have you relied

the name of the patient that can happen to anybody. That can happen to me tomorrow in a busy day at the office. The actual procedures weren't performed on a patient and they're so infrequent as to not even -- the doctor himself has enough sense to know that he made a mistake and try to do something about not doing something like that again. And he had some help from the nurses on the floor ln one case.

And this third thing about pushing the nurse's hand out of the way with a sucker, I've done that. In neurosurgery very often what we have to do is move our whole body and get the assistant out of the way in a hurry. I've explained to them afterwards, this is just how you have to do it when you want to get a quick change of view of the field. And this was with a patient who was deathly ill. I mean, this was in the middle of an emergency and he pushed the guy's hand with a tonsil suction, I mean, big deal. That isn't even worthy of an incident report. That's a laugher, that's a laugher, that's absurd.

Q. Do you have any other opinions in regard to that particular incident report?

A. No.

Q. When, approximately what time of the day

A. Yes, it did.
Q. In some cases did it hurt a little bit?
A. Yes, it did.

Q. Did you cry or quit or do anything?
A. I moved my hand.

Q. Okay. Why?
A. Because that was what he obviously wanted.

Q. Okay. And likewise, have you had a surgeon take your hand when you're a scrub nurse and move it away with his hand?
A. Yes, I have.

Q. Has that happened on more than one occasion?
A. Oh, yes.

Q. By doctors other than Dr. Bryan?
A. Oh, yes.

Q. Have any persons instructed you to write up any surgeon who touches you or moves your hand aside?
A. No, they haven't.

Q. Let's back off now and ask you if you're aware of a way of complaining about the actions of doctors at Holmes Regional. Do you know what an incident report is?
A. Yes, I do.

Q. Would you tell the jury what your understanding of an incident report is.
A. An incident report is to be used if something

Q. Now, Dr. Foley, who is the medical director of the hospital, is the same Dr. Foley that you have told counsel for the hospital would push your hand aside with a retractor?
A. Uh, huh.

Q. That's a yes?
A. Yes, yes, I'm sorry. Yes.

Q. And the same one that had yelled at you?
A. Yes.

Q. And had a temper?
A. Yes.

Q. And yet he has been made the director of medicine at the hospital and not suspended?
A. Right.

Q. To your knowledge, did either Sarnowski or any of the other doctors, they were all good surgeons, too?
A. Yes.

Q. Did they ever lose their staff privileges?
A. No.

Q. Dr. Armstrong and Dr. Gurri and Dr. Foley, in your opinion as a member of the hospital operating room suite, are they powerful politically?
A. Yes.

MR. KAY: Objection.
BY MR. MOSS:

cardiac arrest, the patients can bleed to death from it. And you're particularly concerned about this in a patient with coronary artery disease. So that's a relatively urgent problem, false aneurysm in the groin, particularly if it's enlarging fairly quickly, which is my understanding was the case here.

Q. All right, sir. Dr. Blackshear, based upon your review of what is called the Tina Stark incident report, what you have there in front of you, involving the aneurysm, that is, you have described it, do you have an opinion based upon your experience and training as a vascular surgeon whether or not this pushing away or this contact, this physical contact of the hand of Tina Stark by Dr. Floyd Bryan during that aneurysm procedure, whether that was an improper procedure by Dr. Floyd Bryan?

A. Yes, I do.

Q. What is your opinion?

A. My opinion is that it was not.

Q. Can you explain that?

A. Well, I didn't see anything in the description of what was going on here, either in the incident report, and I can't remember if I mentioned earlier, but I also reviewed some of Dr. Bryan's responses to these reports initially also. I can't see anything in

them that really relates to anything out of the ordinary. One, vascular surgery is a specialty which is somewhat stressful. Bad things can happen quickly. A very smooth operation can, over the course of a few seconds, deteriorate into a disaster if one loses control of a major blood vessel. The hemorrhage that can occur from a major blood vessel in a very, very short period of time is massive and it may threaten the life of the patient or certainly may increase the need for blood transfusions, and I think we're all aware of the problems associated with blood transfusions these days. So certainly maintaining control of the blood vessel, particularly a major blood vessel with a false aneurysm, which may under circumstance being [sic] infected because it has occurred through contact from the skin, is a very, very important and very significant thing. And if a piece of equipment is not functioning properly or if, if it's not set up properly or not being handed properly, the surgeon's obligation is to get it, period. Because there is really only one priority there and that's to stop the hemorrhage. If the patient's bleeding, that can't be tolerated.

Q. Dr. Blackshear, based upon that, which in your opinion is more important, the welfare of the patient

or any hurt feelings of a tech or a nurse?

A. Well, there is only one priority in the operating room and that's the welfare of the patient that's on the operating table.

Q. Now I want you to assume, sir, when you referred to Dr. Bryan's replies during the Dr. Chanda Panel and you referred to that, I want you to assume that Dr. Bryan, and this is a matter of record, testified before the Dr. Chanda Panel that he brushed Tina Stark's hand away during that aneurysm operation. Is that an improper act on his part under the circumstances of that aneurysm operation?

A. I don't think so.

Q. Did you see anything about the Tine Stark incident, that is, the aneurysm patient as you have described, which would just justify, based upon your experience and your training and your background of many years, which would justify Dr. Floyd Bryan being suspended of his medical staff privileges by Holmes Regional Medical Center?

A. Absolutely not.

Q. Why not.

A. Well, the incident is almost trivial in my estimation. And certainly whatever happens in the operating room, one has to keep in mind that the

A. Well, I don't believe that there was, the least bit unusual about this incident. I would not confine it to vascular surgeons. I think any surgeon often uses that maneuver of, either using their hands or whatever instrument they happen to be holding, to hit a retractor, and the message is, pull hard, pull further, it's a commonly understood method of communication in the operating room. And it's particularly useful whenever you're trying to do six things at one, which is the case in an operation like this. This was a gunshot wound to the upper abdominal aorta, the biggest blood vessel in the body and one of the spots in the body at which it is most difficult to see. It's exceedingly difficult to get exposure in that area under the best of circumstances, and when you have a huge hole in the blood, in the artery and the blood is powering out from everywhere, it's often almost completely impossible. So this sort of maneuver would be a routine maneuver during this procedure. One that i myself use many times, I have had used on me nay times and probably will have used on me any times in the future.

Q. Doctor, was this a life-threatening situation?

A. Absolutely. Obviously, the patient died.

Q. And when you have a life-threatening situation,

Has it been your experience and training that sometimes you have to do things abruptly and quickly?

A. Yes.

Q. Why?

A. Well, simply because you don't have time to discuss an action with a person that you might like them to engage in. Obviously it would be nice if everybody had the time to sit and explain the whys and wherefors of everything. But whenever you are working in an emergency situation like this, that simply is not available to you. You have got to do whatever is necessary, as quickly as is necessary and you can't stop what you're doing and take time to talk to another individual or request that they do this. In fact, you may be talking to somebody about something else at that point in time, and hit a retractor and if the hand's in the way, the hand gets hit and nobody usually thinks much about it. Kind of allows you to be a little more efficient. You're doing two things at once.

Q. All right, doctor, now this is the last instrument [sic] report. My question to you, sir, based upon your review of it and based upon what you have already told us in your opinion, first of all, do you have an opinion as to whether or not that physical

contact by Dr. Bryan under these circumstances involving Mike Greene, whether that was sufficient to warrant a complete suspension of Dr. Bryan's surgical privileges at Holmes Regional Medical Center?

A. Yes, I do.

Q. What is your opinion?

A. My opinion is that it wasn't.

Q. And would you please explain briefly why you are of that opinion?

A. Well, I don't know what else to say other than what I said earlier, in that this is a routine maneuver in the operating room, one that I use constantly, most of the other surgeons that I know use it constantly. And certainly if anybody's hand is in the way whenever you're hitting a retractor, it's unfortunate, but I don't know of anyone who has any malice in that action, they simply are trying to achieve a goal. That is, to do the operation as quickly and as efficiently as possible. If there is malice in it, the it's, obviously it's a different situation. But I saw nothing anywhere in the incident report or any comments about it that indicated that that was the case here.

Q. Doctor, incidentally, have you ever been asked to give a lecture at Holmes Regional Medical Center?

correct the stop cock while he was trying to get the stop cock and do it all himself. And without expressing this verbally, he just grabbed it, hit her hand, knocked her away, took it so that he could maintain control since he felt like it was up to him now to do it. And that's what precipitated the thing --

Q. All right, sir.

A. -- the whole situation.

Q In your time in the operating room, have you become familiar with the term of non-verbal communication?

A. Well, maybe not from being in the operating room, but just from general experience.

Q. All right, sir. Is it unusual to push people's hands aside or tap them or hit them?

A. I don't think so. I think there are different personalities and I think some people like to plan things out in their mind, go through things very carefully. Like in an operation you may be thinking several steps ahead. Other people like to talk a lot and to communicate. And when something suddenly happens, it's hard to just formulate a description and say get it done quickly, it's easier to just grab or put your hand. Or if a child is going to the stove,

it's a lot easier to grab his hand or slap it away rather than to give an explanation of why you shouldn't be doing that or think of something to say. I know instinctively you just reach out an do something when it has to be done quick.

Q. And likewise, the incident involving the gunshot victim who was bleeding, did you read that?

A. Yes, I did.

Q. In your opinion, were any actions of Dr. Bryan during that striking the hand of an operating room technician with a suction device unprofessional?

A. I really, I didn't think so. I thought that from my knowledge of what goes on in the operating room, something like that wasn't so unusual.

Q. In totality, if you add, instead of taking each one separately, if you say that all four of these occurred in a period of a month and a half, do they indicate that Dr. Bryan is losing it, that the is a danger to patients?

A. I don't think so. There was an incident where I think it was in that second case where there was so much bleeding going on where Dr. Bryan needed something, the nurse was on the telephone. He wanted something from the nurse that was on the telephone and I think what happened was she was involved in this

A. Yes.

Q. Without asking your permission?

A. Yes.

Q. Have you ever had him hit you with his hip to get you out of the way when you're standing there?

A. I wouldn't say hit. I would say nudged.

Q. Nudge. Without saying Miss Fabian, would you be kind enough to step to your left two paces or anything?
A. They usually don't take the time to say that.

Q. Have you ever had a surgeon in the midst of an operation with blood squirting out move your hand rather quickly without again asking your kind permission?
A. Yes.

Q. Does that go on every day at the Holmes Regional Medical center?
A. I would say to some degree, yes.

Q. And you said that you would find it to be a personal attack or something if someone slapped you or -- do you consider it a personal attack if a doctor nudges your hand, grabs your hand, moves it aside, taps you with an instrument?
A. No.

Q. Have you had doctors speak harshly to you, Miss

Q. Are these the very self same incident reports which were referred to in the Dr. Chanda Panel at the last evening?

A. Yes, they are.

Q. All right. Now, sir, based upon your experience and your review of the materials that you've described, have you arrived at an opinion as to whether any reasonable physician, acting as a member of the Medical Executive Committee at Holmes Regional Medical Center, could have reached the conclusion that the four incident reports, which we have referred to, together with the prior incident reports, were serious or significant enough to recommend that Dr. Bryan lose his privileges?

A. Absolutely not.

Q. Why?

A. First of all, an incident report is somewhat of an accident report to a degree indicating an unfortunate or accidental circumstance that takes place in the care of a patient, which could be detrimental to patient care and needs to be documented. Somebody slips and falls in the hospital, falls off a stretcher, falls off an x-ray table, and it's usually something significant and something relating to patient care.

Q. A what?

A. A cannon ball go through half of her body.

MR. KAY: Your Honor, we have to strike. This again doesn't go to the four incidents and the subject of testimony.

THE COURT: Sustained.

BY MR. METZGER:

Q. Dr. Guy, based upon your review of those four incident reports, do you have an opinion, taking every word that you read in those four incidents as being absolutely true, do you have an opinion as to whether they formed, either singularly or together, a basis for taking Dr. Bryan's privileges away permanently?

A. Absolutely not.

Q. And why not?

A. I don't think they're of enough gravity to warrant suspension from the staff. I think that type of punishment is far too severe.

Q. And then to move on, I'm almost through, considering that he did have some problems in the past and we're aware of some incident reports, I think as many as twenty three prior incident reports spanning ten years. Even taking those -- have you reviewed those?

A. No.

They looked into that, they found that stack really wasn't that big, that there were a lot of duplicates and then when they looked at what was left over, there were a lot of trivial things that they thought weren't significant. And that consequently, they discounted the argument that there was a big stack of complaints, that there really weren't a big stack of substantial complaints.

Q. Were you aware that Dr. Bryan was suspended in 1988?

A. I have learned of that subsequently. I don't think I was at the time.

Q. Dr. Ryon tell you that?

A. I don't think I knew that at the time.

Q. Are you aware of the fact that in 1989, Board of Directors of the Hospital told Dr. Bryan that he felt, that they felt he had acted in a disruptive and unprofessional way and that if he continued to act that way, he would lose his privileges?

A. No.

Q. Would that be significant to you if the Board of Directors of the Hospital issued such a warning?

A. I would take serious notice of that.

Q. Directing, going on further in that same third point, I believe there is a specific reference to that

permanently the privileges of Dr. Floyd Bryan.

Q. All right. Dr. Kucera, assume, and this is a matter of record, it's in evidence, the Dr. Chanda Panel recommended a suspension of two years, and further assume, it's a matter of record, the Medical Executive Committee then chose to permanently revoke Dr. Bryan's privileges. Do you have an opinion as to what basis, what reasonable basis, if any, they had in doing that?

A. Well, the Executive Committee has the option, they can affirm, modify or completely change the recommendation of that Hearing Panel. They are entitled and allowed by the By-laws to do that. But in the record I could find no reason why the two year suspension recommended by the Hearing Panel was turned into a permanent suspension with no opportunity to ever reapply. The reasons for that action are not given in the records I reviewed.

Q. Do you have an opinion as to whether the Defendants acting as members of the Medical Executive Committee acted fairly towards Dr. Bryan in revoking his privileges?

A. Well, that particular incident violated the rules of fairness and the American Medical Association Code of Ethics because in any Hearing Panel the

physician, the doctor who whose privileges are being investigated or denied or changed has the option, according to the rulings of fairness, to hear the testimony and to address it and give his reasoning for the actions that took place. In that particular instance, Dr. Bryan was not present, he was told, I think previously, that those issues would not be addressed, and then they were addressed in his absence without an opportunity to respond. And that is in violation of due process and that is in violation of the American Medical Association code of ethics.

Q. Now, sir, referring to the Medical Executive Committee Minutes of July 10, 1989, and let me get them for you, they've been marked into evidence, I've got my copy, but let he get the exhibit number. Referring to the Executive Medical Committee minutes of July 10, 1989.

All right, sir. I'm handing to you, or with the Court's permission handing to you the Executive Committee Minutes along with other minutes, but the ones I'm referring to and I'll ask you a question or two on are the minutes of July 10, 1989 of the Medical Executive Committee of Holmes Regional Medical Center. May I approach?

THE COURT: Yes, sir.

[TEXT OMITTED DUE TO
DEFENDANT'S OBJECTION AT TRIAL]

Q. do I understand correctly that the first time you saw the four incident reports was earlier today?

A. Yes, sir.

Q. In regards to the Chanda panel's review of those four incident reports do you have any opinion?

A. Yes, I do. If they concluded that this

guy was unfit to practice in the hospital on the basis of those four incident reports, there was something very wrong with that panel. I don't know what it was, but there was something very wrong with that panel.

Because I was known as a law and order president of the staff. If those four incident reports appeared on my desk, three of them I would have thrown into the waste basket immediately and the first one involving the hitting the nurse's hands I would have called the doctor and tried to clarify it. And to me just reading it it sounds like one possible excuse was that she was about to do something dangerous and he was afraid that just by doing it verbally that she would go ahead and do it anyway. And by physically interrupting her actions he was able to avert a catastrophe.

But because of the nature and sensitivity of the issue, I would have probably called the guy up and found out what was going on. Something, by the way, which the chief of staff of your hospital never did. He said he never saw those incident reports, Gurri did.

Q. Did you bring any records with you today?

Q. Were some Surgeons?

A. Yes.

Q. All right. Go ahead. I didn't mean to interrupt you.

A. I was in a very difficult position because clearly, this thing had reached a climax, and there are camps that were forming, and it had gone on with Floyd for years before I had gotten there, and as a new staff member, I was in an awful position because I thought I saw an injustice of the system. I make no pretense to know how it got there over a ten-year period or any of the circumstances around it, but I felt it was almost like a McCarthy-like hearing that was going on. I had no understanding of how it could go to that level, and because of that, I felt I should at least speak to that issue.

MR. KAY: Move to strike.

THE WITNESS: The other part about it was that there -- the camps were so well defined where people were either supporting what he did or not supporting what he did, and the ones who understood that I was going to be going to the hearing said exactly that. I don't know why you're doing that. You're going to really put yourself and your future in jeopardy. You're going to really possibly

A. Yes, he testified for a brief period of time.

Q. And after you arrived at a decision of two years, rather than what the executive committee had suggested, a permanent suspension, what happened next? Do you know? Did you follow this at all?

A. No, no, in fact, no, not at all

Q. Well, let me ask you to assume hypothetically that the executive committee following receiving the panel recommendations of two years, said no, we want a permanent suspension, overruled you. Assume that to be true.

A. Well, we assumed that would be true. Just I mean, we did assume that.

Q. And who was the chairman of the executive committee that overruled your decision?

A. Well, it would have either been Dr. Mills or Doctor, Dr. McClure, I presume, whoever's -- I don't know who it was.

Q. Well, let me ask you to assume it was still Dr. Mills. And then from there, Dr. Bryan's given a right to appear and he appeals to the board of trustees. Were you aware that that happened?

A. We knew from the bylaws that Dr. Bryan was, would be allowed an appeal at the board level if the executive committee, whatever the executive committee

had said.

Q. All right, sir. And do you know, sir, that Dr. Armstrong was also on the executive committee that brought the charges?

A. Yes, he was chief of surgery at the time.

Q. He testified in front of the panel?

A. Yeah, he did testify.

Q. He did, didn't he? Remember that?
A. Yeah, I though you --

Q. And then, he was on the executive committee that reversed your decision?
A. They did not reverse our decision.

Q. Well, they added lifetime to two years, didn't they?
A. Yeah, I wouldn't consider that a reversal of decision.

Q. Well, let's just say, did they change the punishment?
A. Yeah. Two years is a pretty stiff penalty. Yes, they changed or they had retained the same decision that they had made originally.

Q. Didn't look like anything you did changed their mind, did it?
A. No. I wouldn't think that it would have.

Q. Do you know, sir, that Dr. Armstrong is a member

HEARING OFFICER LOVERING (cont'd):

1989, and I announce on the record to counsel that you're informed of the notice of this hospital record.

With that, I am ready to announce the ruling insofar as the prior misconduct is concerned or the prior alleged misconduct. The committee is not going to receive evidence of misconduct or disruptive behavior or incidents of misconduct or disruptive behavior occurring prior to the hearing panel convened and chaired by Dr. Ryon. And that was in May of '89, I believe. Maybe you've got a better recollection of the date.

MR. MOSS: It was concluded in May of '89, I believe.

HEARING OFFICER LOVERING: All right. Any incidents prior to that time, the committee will not permit evidence, any evidence relating thereto. The committee is aware of the report of the Ryon hearing committee and doesn't agree or disagree with the merits but wants to state on the record that they are familiar with that report and draw no conclusions from it.

With that, Mr. Storms, if you're ready

to proceed, sir.

MR. STORMS (attorney for the hospital): Yes, sir. Mr. Lovering, am I to understand that the ruling of the hearing officer is that the records of the hospital relating to Dr. Bryan will not be admitted?

HEARING OFFICER LOVERING: You are correct if you are saying that the prior incident reports involving misconduct or unprofessional behavior prior to the final report of the Ryon hearing committee in May of 1989 is not going to be received in evidence.

MR. STORMS (attorney for the hospital): All right. So may I call the attention to the hearing officer of the provision in the bylaws which is 43.8, which talks about basis for decision. "The decision of the hearing panel should be based on the evidence produced at the hearing. The evidence may contain the following: Any material containing the hospital files regarding the person who requested the hearing so long as this material has been admitted into evidence and that copies have been provided to the person involved." And

so I understand that it is the ruling of the chair that with respect to those records, only those records that had occurred subsequent to Dr. Ryon's panel will be admitted; is that correct?

HEARING OFFICER LOVERING: That's correct. And that would have to relate to the incidents that are set forth in the letter to Dr. Bryan of March 9th and May 16th, two on the 16th of May and one on March 9th, I believe. Correct me if my dates are wrong.

MR. STORMS (attorney for the hospital): I think it's the 7th and the 16th.

HEARING OFFICER LOVERING: All right. The 7th and the 16th.

MR. STORMS (attorney for the hospital): All right. We would go ahead and call Nancy Runge as our first witness. Let me go get her.
WHEREUPON:

NANCY RUNGE,
a witness herein, having been duly sworn, did testify upon her oath as follows:

DIRECT EXAMINATION
BY MR. STORMS:

MR. STORMS (attorney for the hospital) (cont'd):

the Health Care Quality Improvement Act. I am informed by Mr. Geary at this time that apparently you were unable to get in touch with Mr. Metzger to confirm that stipulation; is that correct?

MR. GEARY: Correct, but I've also reviewed all the correspondence between yourselves and, as you know, everything that passed between us has been confirmed in writing. There is nothing confirming the stipulation that you're alleging.

MR. STORMS (attorney for the hospital): There's no question about it not being in writing. I spoke to counsel for Dr. Bryan here at the hearing the last time and we had that stipulation and I assume that as most attorneys he would honor his stipulation and I assume he will when you can ask him.

On another matter of housekeeping, I would proffer -- I recognize what the chair's ruling is with respect to prior incidents. I would just proffer these and ask they be marked as exhibits, that which is entitled "Miscellaneous Incident Reports" and that which is entitled "Action Taken, Conduct

Correspondence."

HEARING OFFICER LOVERING: Mr. Storms, certainly we'll mark that for identification. I think, you know, both sides --

MR. MOSS: Subject to your prior ruling, isn't it, Mr. Lovering?

HEARING OFFICER LOVERING: Yes. I think both sides ought to put whatever record they feel is adequate and we will not receive it in evidence but it will be marked as being proffered and marked for identification.

MR. MOSS: I might say for the record I've never seen those documents. They're very attractively bound and beautifully colored and I don't know what they are so I object to them.

MR. STORMS (attorney for the hospital): For the benefit of the record I would say that everything which is contained in those documents has been provided to counsel for Dr. Bryan in exactly two different versions, one initially and at the last hearing they wanted a copy in that particular version and copies were provided in that version, so I don't know whether Mr. Moss was provided with them but Mr. Geary

was.

MR. GEARY: I was provided with sanitized, excerpted minutes and when we got here August 7th we found a stack about that much bigger. (Indicating)

HEARING OFFICER LOVERING: Sure. Okay. We've already ruled on this. We will mark this pink volume "Action Taken, Conduct Correspondence" as Hospital's Exhibit 1 for Identification and this second volume which is pink also marked "Miscellaneous Incident Reports" as Hospital's Exhibit 2 for Identification only.

(Whereupon Hospital's Exhibit 1 and 2 were marked for Identification.)

MR. STORMS: We would like to call Dr. Mills as our next and last witness on behalf of the hospital.

BARRY A. MILLS, M.D.,
the witness herein, after being duly sworn, did testify upon his oath as follows:

DIRECT EXAMINATION

BY MR. STORMS:

Q. For the record, will you state your full name, please, sir?

DR. CHANDA: Okay.

HEARING OFFICER LOVERING: Thank you very much, Doctor.

THE WITNESS: Thanks. Thank you for the opportunity to speak.

(Whereupon the witness was excused.)

DR. CHANDA: Mr. Lovering, could I request a brief discussion with you in the absence of counsel?

HEARING OFFICER LOVERING: Yes. Would you please give us --

MR. MOSS: Are we supposed to go home?

DR. CHANDA: No, no.

HEARING OFFICER LOVERING: No, just give us a few moments.

(A discussion between Hearing Officer Lovering and the Hearing Panel was held off the record, outside the presence of counsel and parties.)

HEARING OFFICER LOVERING: This will be received as Dr. Bryan's Exhibit number 6 and it was previously marked Dr. Bryan's Exhibit 1 for Identification.

Other than that, I think the record of the evidence is all straight.

Gentlemen, the committee has elected to

receive into evidence as Committee's Exhibits B and C what was previously marked as Hospital's Exhibit 2 and -- 1 and 2 for Identification and these are the prior disciplinary records of Dr. Bryan that were proffered on behalf of the hospital.

MR. MOSS: What can I say? Of course, had it been done during the time I could have presented testimony. I could have presented testimony as I did in the first hearing about those reports but the committee having elected to receive them, I don't know what to say other than I felt this was a closed case. But be that as it may, I don't know what's an appropriate reaction at this hour other than I -- we had made our arguments to the hearing panel, the hearing panel has ruled. If the committee wants to see them, I don't know what I can do about them other than there they are.

HEARING OFFICER LOVERING: The committee would like to have them in evidence.

(Whereupon, Dr. Bryan's Exhibit 6 was received into evidence.)

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(Whereupon, Committee Exhibits A and B were received into evidence.)

A. No, but we never head the side of the people who had written the incident reports, we did not discuss those incident reports.

Q. Well, the incident reports are what? Just tell the jury, they haven't seen them yet. What goes into an incident report? When are they written? Who writes them?

A. Anybody at a hospital can write an incident report about anything. That's my understanding of how the system works. Whether it is a patient received the wrong medication, that's an incident. Anything that is above and beyond what is considered to be normal. And so, so anybody, if a patient slips on the floor, falls out of bed, if something is broken, a blood specimen is lost, an incident report could be written for anything that is considered to be over and above what is everyday, an everyday occurrence.

Q. What is the difference if the physician who is charged in an incident report doesn't ever hear about the incident report, between an incident report and say talking behind somebody's back?

A. I mean, I presume an incident report could be considered to be hearsay if somebody make a complaint that you're never given an opportunity to defend yourself. But that's not, I don't think that's

hearings.

Q. All right. And did you, sir, review at some point prior to voting review those incidents reports which are in front of you?

A. Yes, sir.

Q. Did the defendant in that case, the plaintiff in this case, Dr. Floyd Bryan, have an opportunity to present any evidence whatsoever concerning the truthfulness of those incident reports?

A. Not at our particular hearing, no.

Q. And did you, sir, in assuming that as to deriving the punishment to be imposed, reach some sort of conclusion in your mind concerning Dr. Bryan and whether he had been a disruptive physician over the years?

A. It was the impression of the panel and myself included that there was disruptive behavior.

Q. And what was that based on, sir?

A. Based on the combination of the incidents provided from previous incidents as well as the testimony at the hearing.

Q. Okay, sir. And do you recall, sir, seeing various evidence of the executive committee minutes that were introduced into evidence where the executive committee, for example, felt that the incident

panel that this was not an error on Dr. Bryan's part but it was a miscommunication.

Q. And as a result of his not appearing, did the records of the minutes in front of you reflect that the executive committee voted not to discuss the matter with Dr. Bryan?

A. Yes.

Q. And they went ahead and voted to suspend him for four weeks?

A. That's correct.

Q. And his side of the story wasn't heard until the panel; is that a fair statement?

A. Yes.

Q. Okay. Now, sir, at the hearing panel, do you recall that at some point during the hearing, it was introduced by representative of the hospital, a stack of incident reports that went back to, I believe it's as early as 1978. Let me hand you defendant's 1 and ask you, flip through those and see if they are incident reports that were discussed by your committee in part back in 1989.

MR. KAY: Sorry, did you say in part?

MR. MOSS: Yes, sir.

A. Well, there was a stack of incident reports. I can't tell you here now if this is the exact stack.

There were a number of incident reports, the panel really didn't spend much time on those because they were, we did not know ahead of time they were going to be at issue.

Q. All right, sir. Were they introduced to prove or to show that Dr. Bryan had a long history of disruptive behavior?

A. I would guess that they were.

Q. Now, did you hearing panel in its deliberations discuss whether these incident reports would serve as a basis for discovering that Dr. Floyd Bryan had a long history of abusive and disruptive behavior?

A. Ask that again.

Q. I'll ask it again. Those incident reports in front of you, there was charged, were they not, by Mr. Storms that the hearing panel, that Dr. Bryan wasn't really being tried or suspended for four weeks for these three matters that you read earlier, it was a culmination of his long and abusive history; is that a fair statement?

MR. KAY: Object to the form of the question. It's leading and also calls for hearsay.

THE COURT: Sustained.

Q. What was your understanding of the purpose of the hospital attorney introducing incident reports

into evidence which had nothing to do with the charges?

MR. KAY: Objection, calls for speculation on the part of this witness.

THE COURT: Overruled; he was part of the panel.

A. I think that, that the -- I don't think these incident reports had that much in there, Mr. Moss.

Q. Now I found the missing document. Let me hand you defendant's 93, which is a portion of the transcript of the executive committee minutes. Do you recognize that, sir, as being the basis upon which the graduated punishment was to be based?

A. Yes, I do.

Q. All right, sir. And would you publish to the jury what if anything the ad hoc committee or the executive committee of the, the executive committee had stated to Dr. Bryan concerning whether he would be advised of any incident reports.

A. Well, I think the inference is that, that he should have been notified.

Q. All right, would you read just that portion that discusses what they would do as it relates to Dr. Bryan.

A. The penalty?

the incident reports were reviewed, the following recommendations were made. Any further written complaints to be reviewed by the subcommittee and interpreted as either significant or insignificant. If felt to be significant, the committee will discuss the report, possibly review the employee involved as well as discuss with Dr. Bryan.

Q. Did that form any part in the conclusion of the committee concerning the discussion of incident reports with Dr. Bryan?

A. Well, the committee didn't feel that there was a discussion of incidents with Dr. Bryan.

Q. And specifically that big stack in front of you, what was the decision, if you will, of the Ryon committee, of which you were a part, concerning whether Dr. Bryan had had those incident reports discussed?

A. I think the assessment of the committee was that those incident reports were not discussed with Dr. Bryan. Not in toto.

Q. And let me direct your attention to a document which I will hand you, which is number 400 for the plaintiffs. A letter addressed to Mr. Means from Dr. Ryon. Would you take a second and -- have I shown you that before today?

EXECUTIVE COMMITTEE
May 29, 1990

A called meeting of the Executive Committee was held on Tuesday, May 29, 1990 at 6:00 P.M. in the Executive Board Room.

Those present were:

Barry A. Mills, M.D., Chairman
Joseph A. McClure, M.D.
Joseph A. Gurri, M.D.
Pablo Enriquez, M.D.
Raymond A. Armstrong, M.D.
Lyle Saltzman, M.D.
Terry Koubek, M.D.
Timothy Reid, M.D.
Angel Quinones, M.D.
Pio Sian, M.D.
Scott Gettings, M.D.
Alfred Tortorelli, D.D.S.
Ronald Levy, M.D.
Mahesh Soni, M.D.
Peter Koretsky, M.D.
Michael J. Foley, M.D.
Michael D. Means

The meeting was called to order at 6:05 P.M. The purpose of this called meeting was to review three incident reports on Physician #01033, one dated March 11, 1990 and two dated May 16, 1990. Dr. Mills read a letter to the Executive Committee from Dr. Armstrong (Chairman, Department of Surgery), Dr. Mills (President, Medical Staff) and Michael Means, (CEO) requesting an investigation of the two incidents which occurred on May 16, 1990. Physician #01033 was placed on administrative suspension on Friday, May 18, 1990 for a 30-day period pending an investigation by the Executive

Committee.

At a called meeting of the Executive Committee on April 9, 1990, it was the recommendation of the Committee that the clinical privileges of Physician #01033 be suspended for a two week period due to a review of an incident which occurred on March 7, 1990 involving the striking of a nurse in the OR. Physician #01033 has requested an appeal in light of this recommendation.

The first witness interviewed was Michael Green, RN, who described the incident as it happened on May 16, 1990 at approximately 10:30 PM in OR #6 as he was assisting Physician #01033 with an emergency gunshot wound patient. Mr. Green stated that Physician #01033 was already annoyed with ER because they had intubated and tried to resuscitate the victim without transferring him directly to the OR as he states he told them on the phone to do. Mr. Green had inserted a foley catheter and was attempting to retract and hold for Physician #01033 in the abdominal area where profuse bleeding was taking place. Instead of instructing Mr. Green to move his hands, Physician #01033 struck his hand with a metal instrument. Mr. Green advised that his hand was struck with such force that he

felt the pain for approximately 5-10 minutes afterwards, but rather than begin a verbal confrontation in an already extremely tense environment, he chose to be relieved in the OR by Ms. Frazier and write up the incident after leaving the OR. He stated that in his entire hospital career, he had never been struck in this manner and that he felt the behavior inappropriate and unprofessional and intends to bring legal action against the physician.

Bill Kaufmann, ORT was also interviewed regarding this incident and stated that he saw and heard Physician #01033 strike Mr. Green with the instrument, but does not remember whether Physician #01033 asked or inferred that he wanted Mr. Green to move his hands. He stressed the fact that the action was deliberate and forceful. He also explained the high level of stress involved in a trauma situation of this type, but also says that he has never seen a physician act this way even during trauma or other surgical procedures during his employment as an OR Tech.

Delores Frazier, R.N. was invited into the meeting. She stated that Physician #01033 asked her to call Dr. Armstrong and ask him to assist in this trauma case. When she reached Dr. Armstrong at home, he informed her that he was ill and could not come in. Ms. Frazier says that when she told Physician #01033 and asked if he wanted her to call someone else to assist, his answer was, "If Dr. Armstrong, Chief of Surgery, cannot be here, then I don't want you to call anyone else." She says that she relieved Michael Green shortly afterwards in the OR but was not in the room during the incident.

Physician #01033 was interviewed regarding this incident. He described the events that occurred on the evening of May 16, 1990 beginning with a phone call from the ER regarding the case coming in of a young, white male with a gunshot wound to the abdomen. He came to the ER and was distressed to find that the patient had not been taken to the OR as he had instructed on the phone initially. He graphically described the entire operation, but when questioned about the incident of his "hitting" Michael Green, he claims that he does not remember this happening. He claims that the first he heard of this was when he received a copy of the incident report. He suggested that if he felt the need for Michael to move his hands, he would have "tapped" him or asked him, to move his hands as so often had happened on other occasions and in his training program. He stated that he has written a letter to Mr. Green apologizing for the incident.

The other incident that occurred on May 16, 1990 involved a patient by the name of Sandra Capitani, a patient of Dr. Isaac Kalvaria's who had been admitted for treatment of pancreatitis. At 3:30 P.M.,

Physician #01033 called 7 West and requested that this patient be prepared for gall bladder surgery. Nancy Runger, R.N. attempted to get the patient to sign a surgery authorization and she refused. The nurse called surgery back to inform them of this and Physician #01033 requested that the patient be brought to the holding room where he could talk with her. The patient had agreed to this and while Ms. Runger was preparing the pre op check list, Dr. Kalvaria arrived and inquired as to why the patient was being prepared for surgery. He was informed that Physician #01033 had stated that gall bladder surgery was to be performed on this patient. Dr. Kalvaria then called Physician #01033, who realized this was not the patient he thought it was, called the OR desk and cancelled the surgery on the patient.

Nancy Runger, R.N. and Dr. Kalvaria were interviewed regarding this incident and stated the above occurred as reported. When questioned about this incident, Physician #01033 said that he thought the patient in question was another patient, with a similar but more complex problem, whom he had seen in his office as a consult several days prior. He assured the Committee that this patient could not have been put to sleep and operated on because he is always in the room with the patients before they are put to sleep and would have realized at that point that this was not the right patient. He claimed it was a case of mistaking one patient for another due to having seen both previously.

The final incident reviewed occurred on March 11, 1990 and involved a patient by the name of Mary Roberts. Judy Botkin,

Nursing Coordinator was present at the meeting and described the incident as follows: on the morning of March 11, 1990, Physician #01033 called SICU to request a bed for a patient needing a pre-op Swan Ganz and that the patient's name was Mary Roberts. The patient was located on 4 North and transferred to SICU in preparation for the procedure. The nursing staff in SICU found that Mrs. Roberts was unaware of any plans for surgery on Monday or plans to insert a Swan Ganz. Concurrently, Dr. Turse arrived on 4N to visit his patient, Mary Roberts and was advised that she had been transferred to SICU per order of Physician #01033. Dr. Turse went to SICU to speak with Physician #01033 and when it was determined this was indeed the wrong patient, Dr. Turse spoke to the patient and her family and Mrs. Roberts was moved back to 4N. Physician #01033 then called SICU and made arrangements for the correct patient to be transferred for the procedure. He then went to Mrs. Roberts room and apologized to her and her family for his mistake.

Physician #01033, when questioned abbout [sic] the above incident, stated that he had intended to call for a patient of Dr. Pocoski's named Mrs. Genheimer, who required a Swan Ganz. He asked for the wrong

patient and accepts responsibility for the incident as human error. Again, he assured the CoMmittee that he would have realized when he saw the patient that it was the wrong one.

Anita Lymhurner, R N., Vice President of Nursing was interviewed and stated that there are five major nursing concerns regarding the problems with Physician #01033. These are (1) staffing - there are nurses and techs that refuse to work with this physician and others that are hesitant to do so: (2) recruitment and retention - due to the tension and stress, including comments often made to new nursing staff, it is becoming increasingly difficult to keep nurses: (3) harm to the staff - verbal abuse, and now physical abuse, would tend to escalate as the problems continue: (4) "image" of the hospital and Medical staff - will be affected by continuing to allow this physician to create problems in the OR and on the floors: and (5) potential for unionization - in order to protect their rights, the nursing staff may be tempted to seek out a union.

After all this information had been discussed and reviewed, the Committee members heard comments from Dr. Gurri, Past President of the Medical Staff, Mike Means, CEO and Drs. Foley and Armstrong about the long-term problems with this physician, the numerous suspensions and interviews, as well as the mandate by the Board that his actions be closely watched for a 12-month period. It was the decision of the committee that due to the escalation of problems involving hospital staff and concern for patient welfare and safety, that a summary suspension of Physician #01033's clinical privileges become effective immediately. This suspension

would not allow Physician #01033 to admit patients, take ER call or take consults. He can, however, care for patients already in the hospital. A motion passed to recommend that Physician #01033's clinical privileges be permanently revoked, with no chance for reapplication.

There being no further business, the meeting adjourned at 9:30 P.M.

/S/ Barry A. Mills, M.D.
Barry A. Mills, M.D.
Chairman, Executive Committee

arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairman of the Board for good cause.

44.4 Nature of Appellate Review:

44.4.1 The Chairman of the Board shall appoint a Board Review Panel composed of not less than three persons, either its own members, reputable persons outside the hospital, or a combination of the two, to consider the record upon which the recommendation before it was made. The Board Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Each party shall have the right to present a written statement in support of his position on appeal, and in its sole discretion, the Board Review Panel may allow each party or its representative to appear personally and make oral argument. The Board Review Panel shall recommend action to the Board.

44.4.2 Action by Joint Conference Committee:

In any case in which the Board Review Panel

number of the Dr. Chanda Panel Report, which is in evidence?

THE CLERK: Plaintiff's 401.

MR. METZGER: May I get it, Your Honor?

THE COURT: Sure.

MR. METZGER: May I approach the witness Your Honor?

BY MR. METZGER:
Q. Handing you, sir, 401 Exhibit in evidence before this Court and Jury. Would you kindly take a look at that, sir.

A. I have read this, yes.

Q. Now you did have the report, but according to your testimony, you did not have the transcripts or the exhibits; correct?
A. At the time of this report?

Q. At the time you made your final decision to ban Dr. Bryan from the hospital permanently.
A. We did not have a transcript at that time, no, sir.

Q. Nor did you have any exhibits?
A. Nor did we have any exhibits.

THE COURT: Mr. Sullivan, I think that Mr. Metzger is getting at, you had that report; you said you had a big pile of stuff, right, that you looked

DEPARTMENT OF PROFESSIONAL REGULATION

MAR 2 1992
PERSONAL AND CONFIDENTIAL

Floyd T. Bryan, M.D.
1402 Oak Street
Melbourne, Florida 32901-3113

Re: Case No. 91-01501

Dear Dr. Bryan:

Please be advised that the complaint referenced above, filed against you by the Department of Professional Regulation regarding allegations that you prepared a patient for gall bladder surgery who was not a candidate for surgery and struck the hands of an OR technician during surgery, has been investigated and the findings reviewed by the Probable Cause Panel of the Board of Medicine. Pursuant to Section 455.225(2), Florida Statutes, and Rule 21-031.001, Florida Administrative Code, the Department finds that there is insufficient evidence to support the prosecution of the allegation that a violation of Chapter 458, Florida Statutes, or the rules promulgated thereunder has occurred. Therefore, the case has been dismissed.

Thank you for your patience and cooperation during the investigation of this matter.

Sincerely,

/S/ Carlos J. Ramos
Carlos J. Ramos
Senior Attorney

CJR/dpb/tc
cc: Joseph Metzger, Esquire

10.2.11. to determine minimum continuing education requirements for appointees to the Staff.

10.2.12. In any instance where a member of the Executive Committee has a conflict of interest in any matter involving another appointee to the Staff or issue which comes before the Executive Committee or in any instance where a member of the Executive Committee brought the complaint against that appointee, that member shall not participate in the discussion or voting on the matter, and shall, at the request of a majority of the Executive Committee, absent himself from the meeting during that time although he may be asked and answer questions concerning the matter before leaving. The Chairman of the Executive Committee, his representative and such members of his Committee as he deems necessary shall be available to meet with the Board or its applicable Committee on all recommendations that the Executive Committee may make, it being the purpose of these Bylaws to increase direct communication between the Board and the Executive Committee on all matters within the scope of the Executive Committee's duties.

99th CONGRESS
2D SESSION

H.R. 5540

To encourage good faith professional review activities of health care entities, to require collection and dissemination to hospitals and other health care providers of information concerning certain payments in medical malpractice claims and certain adverse decisions, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 17, 1986

Mr. Wyden (for himself, Mr. Waxman, Mr. Madigan, and Mr. Tauke) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To encourage good faith professional review activities of health care entities, to require collection and dissemination to hospitals and other health care providers of information concerning certain payments in medical malpractice claims and certain adverse decisions, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1.SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**--This Act may be cited as the "Health Care Quality Improvement Act of 1986."

LEGISLATIVE HISTORY
P.L. 99-660

Much of Title IV of this Public Law was derived from H.R. 5540. House Report (Energy and Commerce Committee) No. 99-903, Sept. 26, 1986 [to accompany H.R. 5540] is set out:

HOUSE REPORT NO. 99-903

[page 1]

The Committee on Energy and Commerce, to whom was referred the bill (H.B.5540) to encourage good faith professional review activities of health care entities, to require collection and dissemination to hospitals and other health care providers of information concerning certain payments in medical malpractice claims and certain adverse decisions, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

* * * * *

[page 2]
PURPOSE AND SUMMARY

The purpose of this legislation is to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior.

Under this bill, hospitals and physicians that conduct peer review will be protected from damages in suits by physicians who lose their hospital privileges, provided the peer review actions meet the due process and other standards established in the bill. In addition, hospitals and physicians

that discipline doctors will be required to report these disciplinary actions to the state medical boards. In turn, the state medical boards will be required to forward this information to the Secretary of the Department of Health and Human Services (" the Secretary") or the Secretary's designee. The bill further requires hospitals to seek this information from the Secretary, or the Secretary's designee, before hiring doctors or other licensed health care practitioners.

The bill also requires paid malpractice claims to be reported to the Secretary, or the Secretary's designee.

BACKGROUND AND NEED FOR THE LEGISLATION

The Committee has reviewed testimony from numerous sources indicating that this legislation is essential to protect the public health and safety.

This bill is needed to deal with one important aspect of the medical malpractice problem in this country--incompetent and unprofessional physicians. It does not address the malpractice insurance crisis, which has extremely complex and controversial origins and cannot be solved through peer review. The bill's focus is on those instances in which physicians injure patients through incompetent or unprofessional service, are identified as incompetent or unprofessional by their medical colleagues but are dealt with in a way that allows them to continue to injure patients.

HEALTH PROGRAMS
P.L. 99-660

Unfortunately, groups such as state licensing boards, hospitals and medical societies that should be weeding out incompetent or unprofessional doctors often do not do so. Even when such bodies do act against bad physicians, these physicians find it all to [*sic*] easy to move to different hospitals or states and continue their practices in these new locations.

The result has been a series of highly visible situations in which physicians with a long history of incompetence or unprofessional conduct have continued to cause needless deaths and injury for years after their damaging behavior was noticed. This legislation would do much to reduce the damage committed by this small, but very destructive, group of doctors. It would require organizations that discipline doctors to report their disciplinary actions to a central location and would require hospitals to seek this information before hiring doctors. It would also require the reporting and dissemination of paid malpractice claims.

To assure that the medical profession cooperates in this system, the Committee believes it is essential to provide some legal immunity to doctors and hospitals that engage in peer review activities. [a]s noted above, under current law and practice, physicians who

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engage in incompetent or unprofessional acts find it very convenient to move to another jurisdiction and resume practice. There are two reasons for this. One is that hospitals too often accept "voluntary" resignations of incompetent doctors in return for the hospital's silence about the reasons for the resignations. Hospitals make these agreements in order to

avoid lengthy and unpredictable litigation. The other is that there is no comprehensive national reporting system to follow bad doctors from place to place.

The reporting system in this legislation would virtually end the ability of incompetent doctors to skip from one jurisdiction to another. The reporting system, however, creates a major problem. Many people in the medical field told the Subcommittee on Health and the Environment that the reporting system would inevitably result in an enormous increase in litigation. The reason: faced with the certainty that they can no longer hide their past records, physicians facing disciplinary action will feel compelled to challenge vigorously any action taken against them. Based on recent experience the Committee believes that many of these physicians will file antitrust lawsuits.

Even though defendants may often win these lawsuits, that may not be sufficient to guarantee enthusiastic or even minimally adequate, peer review. Unlike other activities that may trigger antitrust lawsuits, properly limited peer review plays no essential or important economic role in the practice of medicine. Doctors who are sufficiently fearful of the threat of litigation will simply not do meaningful peer review. The result would be to continue the possibilities for abuse by bad doctors.

Thus, there is a clear need to do something to provide protection for doctors engaging in peer review if this reporting system is to be workable. To that end, the bill provides limited, but essential, immunity. Doctors and hospitals who have acted in accordance with the reasonable belief, due process, and other requirements of the bill are protected from damages sought by a disciplined doctor. The

LEGISLATIVE HISTORY
P.L. 99-660

bill protects innocent and often helpless consumers from abuses by bad doctors without insulating improper anti-competitive behavior from redress.

HEARINGS

The Committee's Subcommittee on Health and the Environment held one day of hearings on H.R. 5110 (and the related bill, H.R. 4390) on July 16, 1986. Testimony was received from 12 witnesses, representing 11 organizations. One witness was a medical director who bad hired numerous physicians without being able to discover even well documented -- sometimes with tragic consequences. Other witnesses represented hospital associations, medical professional groups, the Inspector General of the Department of Health and Human Services, large employers, the Federation of State Medical Boards, and the U.S. General Accounting Office.

COMMITTEE CONSIDERATION

On September 17, 1986, the Subcommittee on Health and the Environment met in open session and considered the bill H.R. 5110. The bill was ordered reported as amended, to be introduced as a

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clean bill, by a voice vote, a quorum being present. On September 18, 1986, the Committee met in open session and ordered reported the clean bill H.R.5540, without amendment by voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(1)(3)(A) of Rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made by the Committee.

COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the bill will have a negligible budget effect for fiscal year 1987 and thereafter because of savings that should result from implementing the reporting system. In the short term, savings would be expected from reductions in the volume of payments under federal programs for unnecessary care or care that is delivered incompetently and results in the need for additional services. In the longer term, savings would also be expected to result from relatively lower hospital expenses for liability insurance.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., September 22, 1986.

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P.L. 99-660

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed H.R. 5540, the Health Care Quality Improvement Act of 1986, as ordered reported by the Committee on Energy and Commerce on September 18, 1986. The bill would encourage hospitals, insurance companies, and other health care entities to report information concerning medical malpractice payments, sanctions for professional incompetence or misconduct, and other professional review actions taken against health care providers. In exchange for reporting, this bill would grant immunity under federal law to hospitals and individuals.

H.R. 5540 would establish a health care provider information clearinghouse to collect and disseminate the reported information on health care providers. The clearinghouse would be run by the Secretary of Health and Human & Services (HHS) or, at the Secretary's discretion, by an appropriate public or private agency. If the clearinghouse is run by HHS, CBO estimates that enactment of this bill could result in costs to the federal government of $30 million in fiscal year 1987 and $10 million in each fiscal year thereafter. If however, the Secretary exercises his discretion to appoint a

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private agency to operate the clearinghouse system, the cost to the federal government could be insignificant.

Hospitals would be required to request information from the clearinghouse prior to hiring any licensed health care

professional applicant. Also, at least every two years each hospital would be required to request information on each member of its medical staff. All of the costs associated with information reported would be borne by private hospitals, insurance companies, boards of medical examiners, and other health care entitles.

Both the Federation of State Medical Boards (FSMB) and the American Medical Association (AMA) maintain data bases containing information similar to that required under the bill. The data collection activities described in this bill would be much more extensive than any that currently exist. Based on rough estimates provided by the AMA, this bill could require approximately one million hospital staff member credential checks per year. In fiscal year 1987, it could cost about $30 million to create the comprehensive data base, to operate the system, and to respond to credential check inquiries. For each fiscal year thereafter, the federal government could expect a cost of about $10 million to maintain and operate the system. These rough estimates reflect the costs of operating a clearinghouse for information only on physicians. Additional costs could be expected since the bill requires the data base to include information on *all* licensed health care professional, not just physicians.

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Please call me or have your staff contact Marianne Deignan (226-2820) if you have further questions.

With best wishes,

Sincerely,

Edward Gramlich
(For Rudolph G. Penner, Director).

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(1)(4)) of rule XI of the Rules of the House of Representatives, the Committee makes the following statement with regard to the inflationary impact of the reported bill:

The Committee reports that enactment of this measure will not have an inflationary impact on the economy. The bill is intended to improve public health and safety by reducing the number of injuries and deaths associated with incompetent or unprofessional medical care by physicians. By reducing the costs associated with incompetent and unprofessional physicians, the bill is likely to have a favorable effect with respect to inflation.

SECTION-BY-SECTION ANALYSIS

Section 1

Short Title and Table of Contents.

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Title I- Promotion of professional review activities

Section 101

Precludes damages against professional review bodies and persons taking professional review actions that meet the standards defined in section 102.

Provides immunity for persons providing information to professional review bodies without knowledge that the information is false.

Suspends protection against damages if health care entity does not comply with reporting requirements of section 203.

Section 102

For a professional review action to qualify for protection from damages it must be taken:

In the reasonable belief that it is in furtherance of quality care;

After a reasonable effort to obtain facts;

After adequate due process;

In the reasonable belief that the action was warranted by facts known.

Characteristics of due process that would be deemed adequate:

Notice of action, with reasons specified;

Right to hearing with notice of time, place, date, and witnesses to testify;

Hearing held before arbitrator or hearing officer or panel not in direct economic competition with physician involved;

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Right to representation, to copies of the record, to call and examine witnesses, to present evidence, and submit written statement;

Right to receive written recommendation and decision. Due process can be different in health emergencies or under other applicable law.

Section 103

Court permitted to award attorneys' fees to defendant who prevails and whose professional review action met standards of the bill.

Court may not award attorneys' fees to plaintiff unless it determines that it would be appropriate to do so.

Section 104

Secretary of the Department of Health and Human Services may establish voluntary guidelines to assist professional review bodies in meeting standards.

Section 105

Activities not covered by this legislation remain under current law, including activities regarding nurses or other practitioners who are not physicians.

Bill creates no requirement that health care entities grant clinical privileges to any or all health care practitioners.

Section 106

Bill applies to actions commenced on or after effective date.

Title II- Reporting of Information

Section 201

Information on paid malpractice claims must be reported to Secretary or designee.

Civil monetary penalties provided for failure to report.

Secretary to study need to report on small payments and also on all claims made.

Section 202

Boards of Medical Examiners must report to Secretary when physician licenses are revoked, suspended, or other actions are taken for reasons relating to competence or professional conduct, or when licenses are surrendered.

Sanction for failure to report is loss of designation under Section 203.

Section 203

Health care entities that take actions adversely affecting clinical privileges for 30 days, that accept privileges during or to avoid an investigation, or that take actions adversely affecting professional society membership, must report information on such actions to the Board of Medical Examiners in that state.

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Health care entities permitted to report similar actions respecting practitioners who are not physicians.

Boards of Medical Examiners must in turn report such information to the Secretary or designee.

Section 204

Reporting must be not less often than monthly and in form and manner prescribed by Secretary.

Secretary of the Department of Health and Human Services may designate an appropriate private or public agency for receipt of required reports. .

Malpractice information reported to Secretary must also be reported to appropriate state Board.

Section 205

Hospitals required to request information reported to Secretary or designee when physician or other practitioner applies to be on staff, and biennially thereafter.

Sanction for failure to report is that hospital is presumed to have such information in a medical malpractice action.

Hospitals relying on such information not known to be false are protected.

Section 206

Secretary must provide for disclosure of information to affected practitioner, and for procedures in case of disputed accuracy.

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Section 207

Secretary authorized to provide information to other health care entities and to State boards, upon request.

Information reported to Secretary is considered confidential, except with respect to professional review activity, medical malpractice actions, or other specifically authorized disclosures.

Civil monetary penalties for violations of confidentiality.

Persons reporting information protected in absence of knowledge that information was false.

Payments of malpractice claims not to be construed as creating presumption that malpractice has occurred.

Title III- Definitions and reports

Section 301

Various definitions.

Professional review action not considered to be based on "competence or professional conduct" if it is based on:

Relationship with professional society or association;

Advertising, charging lower fees, or engaging in other competitive acts;

Financial arrangement for delivering health care;

Relationship with practitioners who are not physicians.

Professional societies not eligible for protection if they have been found to have engaged in anti-competitive practices restricting the practice of other practitioners within previous 5 years.

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Section 302

Secretary to report annually for three years on implementation of this legislation

Secretary of the Department of Health and Human Services to seek to enter into memoranda of understanding with Secretary of Defense and Administrator of Veterans Affairs to apply provisions of legislation to facilities and personnel under their jurisdiction.

Secretary of the Department of Health and Human Services to seek to enter into memorandum of understanding with Administrator of Drug Enforcement Administration concerning revocations of registration to dispense controlled substances.

DISCUSSION: COMMITTEE VIEWS

Title I - Promotion of professional review activities

Section 101. Professional Review

Subsection (a) provides limited, but essential, protection from liability for persons conducting professional review actions based on the competence or professional conduct of individual physicians. To qualify for the protection, the professional review action must meet the standards specified in section 102(a) and must be an action as defined in section 301(9). If those criteria are met, the persons engaging in or assisting in the conduct of professional review action shall not be liable in damages with respect to the action.

The Committee feels that the purposes of this bill

require protection for persons engaging in professional review. Under current

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state law, most professional review activities are protected by immunity and confidentiality provisions. A small but growing number of recent federal antitrust actions, however, have been used to override those protections. Because the reporting system required under the legislation will most likely increase the volume of such suits, the Committee feels that some immunity for the peer review process is necessary.

Initially, the Committee considered establishing a very broad protection from suit for professional review actions. In response to concerns that such protection might be abused and serve as a shield for anti-competitive economic actions under the guise of quality controls, however, the Committee restricted the broad protection. As redrafted, the bill now provides protection only from damages in private actions, and only for proper peer review, as defined in the bill. The bill leaves completely intact the jurisdiction of the Federal Trade Commission, the Justice Department and State Attorneys General to bring antitrust actions. In addition, the bill does not restrict the rights of physicians who are disciplined to bring private causes of action for injunctive or declaratory relief. If the professional review actions being challenged fail to meet the standards of section 102(a), no immunity is provided and the suit can be tried without regard to the provisions of this bill.

Subsection (a) also provides immunity for persons providing information to professional review bodies, unless the information is false and the person providing the information actually knows it is false. The Committee intended to encourage persons to report in-

formation regarding possible incompetence or unprofessional behavior on the part of physicians. Such persons might have no connection with a professional review body, and thus the Committee determined that such immunity would not be made contingent on the propriety of the actions of the professional review body.

Subsection (b) bars immunity for health care entities that do not participate fully in the reporting requirements of section 203(a). The approach used in this legislation reflects the Committee's strong feeling that the current problem of incompetent or unprofessional physicians being able to disappear and leave their history behind must end. This problem can be solved only if hospitals and other health care entities make their findings available to each other through the reporting systems established in this legislation.

Simply conducting professional review to rid a single hospital or a single community of a problem physician without reporting the action is not sufficient to warrant the protection provided under this legislation. Accordingly, health care entities that do not report do not get immunity under this bill. This does not mean that minor or technical flaws in reporting will trigger the loss of immunity. To protect health care entities in this regard, the Secretary is required to follow specified procedures prior to suspending or disqualifying them from the immunity provisions.

The fact that a professional review action was or was not taken against a physician under this bill shall in no way affect the right of a patient to file a malpractice claim or action for damages. Nor shall such failure affect any defenses to such a malpractice action. For example, a patient might seek to include a hospital in a malpractice action where the hospital

has information related to the

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professional conduct or competence of a physician, takes a professional review action that meets the standards of this bill, exonerates the physician, and the patient is subsequently injured by the physician. Although the hospital and the professional review body would not be subject to damages in a suit by the physician, this immunity would not apply to any suit by the patient.

Although the secretary is required to work with health care entities to bring them into compliance, the Secretary is also obligated to act should the Secretary suspect that these entities are out of compliance. The bill requires the Secretary to conduct an investigation whenever the Secretary has reason to believe that a health care entity has failed to report appropriately. Thus, if professional reviewers or even members of the general public notify the Secretary that a hospital is out of compliance, the Secretary will be required to conduct an investigation.

Section 102. Standards for professional review actions Subsection (a) establishes the standards that a professional review action must meet in order to qualify for immunity under section 101. The first requirement is that the action be taken in the reasonable belief that it is in the furtherance of quality health care. Initially, the Committee considered a "good faith" standard for professional review actions. In response to concerns that "good faith" might be misinterpreted as requiring only a test of the subjective state of mind of the physicians conducting the professional

review action, the Committee changed to a more objective "reasonable belief" standard. The Committee intends that this test will be satisfied if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients.

Reflecting the Committee's belief that this standard will be met in the overwhelming majority of professional review actions, the subsection provides a presumption to that effect, requiring a plaintiff to show, by clear and convincing evidence, that no such reasonable belief existed at the time of the professional review action. This presumption applies only to the reasonable belief standard, not to the other standards. Those additional standards require a group engaged in peer review to make a reasonable effort to obtain the facts to provide adequate due process, and to have a reasonable belief that the professional review action was warranted by the facts known.

The due process requirement can always be met by the procedures specified in subsection (b). If the procedures specified in that subsection are provided, the health care entity will be deemed to have met the due process standard. If other procedures are followed, but are not precisely of the character spelled out in subsection 102(b), the test of "adequacy" may still be met under other prevailing law. The Committee is aware, for example, that some courts have already carefully spelled out different requirements for certain professional review activities or actions, such as procedures for decisions regarding applicants for clinical privileges at a hospital. In those situations, compliance with applicable law should satisfy the "adequacy" requirement even where such activities or ac-

tions require different or fewer due process rights than the ones specified under subsection 102(b). In any case, it is the Committee's intent that physicians receive fair and unbiased review to protect their reputations and medical practices.

The Committee intends that the hearing panel or officer be impartial and fair in evaluating a physicians behavior. In order to ensure that reviews of physicians pertain only to quality of care, the Committee has specified that members of the hearing panel, or the hearing officer, cannot be in direct economic competition with the physician-respondent. The Committee recognizes that in many cases, such as small hospitals or group practices, hospitals or physicians in rural areas, or situations involving highly specialized work, this requirement may represent some difficulty. In particular, it may not be feasible to find physicians who are of the same specialty as the respondent but who are not in direct tn economic competition. Nevertheless, the Committee expects the professional review body to make every reasonable effort to find appropriate officers or members of the panel, even if this requires bringing in reviewers from out of town or using physicians of a different specialty.

The Committee also notes that the failure to meet the standards of Subsection 102(a) creates no presumption with respect to the liability or lack of liability of a health care entity. Such failure would, therefore, be inadmissible in evidence in any litigation be-

tween a physician and any person or group engaged in peer review. The only conclusion that follows from a failure to meet those standards is that the entity is not entitled to the immunity conferred under this legislature. The entity is still entitled to the full range of defenses and immunities available under other applicable law and practice.

One of the requirements of due process is notice. The Committee is aware that between the time the initial notice is given of a proposed professional review action and the time of the hearing on that action, the investigation may have uncovered reasons for such an action other than or in addition to the reasons specified in the initial notice. Provided that notice is given in a way that protects the interests of the physicians against whom the action is proposed, a supplemental notice of such additional reasons might well satisfy the requirements of due process.

Subsection (c) modifies the due process required to obtain immunity under section 101(a) during investigations or in health emergencies. Under this provision there is no requirement that due process meet a test of "adequacy" where no adverse professional review action is taken (e.g., an investigation resulting in a decision not to take a professional review action), or during a suspension or restriction of clinical privileges for a period of not longer than 14 days during an investigation to determine the need for a professional review action. In addition due process can be provided after the fact where clinical privileges are suspended or restricted on an immediate basis where the failure to take such action might result in an imminent danger to the health of an individual.

The Committee felt strongly that it was necessary to establish these exceptions to provide for appropriate protection

during investigations and to allow quick action where it would be reasonable to

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conclude that someone's health might otherwise suffer. Nevertheless, these exceptions are not meant to provide a back door for harassment of physicians through repeated short term suspensions or interminable investigations never leading to a professional review action. Such actions could not meet the "reasonable belief" test in subsection 101(a). Health care entities should bring a full-fledged professional review action where such instances repeatedly recur with regard to a specific physician.

The Committee intends that these provisions allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible. The provisions would allow a court to make a determination that the defendant has or has not met the standards specified in section 102(a). The Committee intends that the court could so rule even though other issues in the case remain to be resolved. For example, a court might determine at an early stage of litigation that the defendant has met the 102(a) standards, even though the plaintiff might be able to demonstrate that the professional review action was otherwise improper. At that point, it would be in order for the court to rule on immunity. In such a case the court could still proceed to determine whether injunctive, declaratory, or other relief would be in order.

I think there are studies which establish that indigent patients tend to have a higher post-op infection rate than non-indigent patients.

Is that something that should be subject to peer review?

Dr. WOLFE. It should not be subject if one looks at those two categories--competence, or the lack of competence, incompetent behavior or lack of professional conduct - the studies showing a significant portion of psychiatrists have sexual relations with their patients is clearly not professional conduct.

In this case, you are describing something that is competent and necessary behavior, and would fall outside of the immunity. If a hospital tried to take action against a physician because the physician happened to be more concerned with poor people and had a practice made up more largely of poor people than someone else, that should be the subject of reward, not discipline. I don't think that would even arguably fall within the immunity provisions of this bill.

Mr. EDWARDS. Thank you.

Without objection, the statement of the distinguished Chairman of the Subcommittee on Health and the Environment, Mr. Waxman, and other members of the subcommittee, Messrs. Tauke and Wyden, will be included in the record immediately after the opening statement by Mr. Sensenbrenner.

We are going to have to take a recess for about 10 minutes while we vote. In that period of time, the committee will be recessed.

[Recess.]

Mr. EDWARDS. The subcommittee will come to order.

Minority counsel, Mr. Slobodin.

Mr. SLOBODIN. Thank you, Mr. Chairman.

Dr. Wolfe, I just wanted to see if I could get a better idea of exactly what your position is on the bill at this time. Is it your position that we should, despite some differences you have with the way the bill stands now, it should be enacted in this Congress?

Dr. WOLFE. Well, I think the differences I raise are important ones and they need to be addressed. I don't think they are ones that are insurmountable. The very fact that there was concern about the immunity being too broad initially has led to a whole host of changes such as actions brought by the Justice Department or the FTC are not in the immune category.

The four categories I read and two additional ones I think are critical. If those are not added, we would not support the bill. We are very concerned with the immunity being too broad and anything that can be done to narrow it, such as what has been done already, what I have suggested and there may be other people who have other suggestions, needs to be done.

But the overall-purpose is that we have a real crisis in this country of inadequate discipline of physicians. The hospital level, which may be the most underdone one right now is very much threatened by the Oregon case and lots of others like lt.

Every physician I know in the country who is practicing medicine tells me that there are one or more physicians at his or her hospital who are incompetent and when I say why are they still there, they say we are afraid to bring an action against them be cause they will retaliate and so forth.

Our system of criminal justice provides not merely protection for society by permitting society to rid itself of persons who cause problems, but also a system of protection for persons who are accused and it turns out wrongfully accused. Indeed, we glory in that fact. That is what makes our system of justice a system of justice rather than a system of irrational punishment. In the same way, I say to this committee that it should be an express purpose, not implied, not somehow found somewhere underneath some of the provisions, to protect doctors whose right and whose privileges and whose ability to practice their livelihood may be, and I submit will be wrongfully called into question by procedures permissible under some of the due process provisions of this bill. That is where my problems lie. I remember back in law school we debated the question whether it was indeed true that a criminal justice system is better if it permits a guilty man to go free rather than convicting an innocent man. That is a philosophical issue on which people may differ. Our system, I believe, is based on the theory that it is better for the guilty to go free than the innocent to be convicted. In legislation of the sort, before this committee, a similar principle operates. That is, in a system designed to weed out rotten apples there must be safeguards, through legislation, that "weeding out" not happen wrongfully.

There was testimony this morning, for example, that there was no doubt that were adverse peer review imposed upon a physician because he or she served black patients, or poor patients that that wouldn't come under the immunity provision of this bill. Certainly it wouldn't come within the intent of the immunity, but the committee can take notice, I believe, that when some doctors decide to get rid of the doctor who is serving the black or poor patients, they are not going

to say that is why they are doing it. They are going to say they are doing it because he is not providing good services. It is the same in any employment discrimination case. We are living in 1986, not 1966 or 1956. They don't say get rid of doctors who serve the poor or the minorities. They say he is not providing good patient care. And my goodness, he was a really good doctor until about a year ago. We just don't know what happened. He went bad, and take a look at these records which we've dug up.

We have a real problem, a real problem.

I have seen these things, I have litigated these things. I have heard them. They do happen. They will happen.

Those problems are caught up in this legislation. It is necessary not merely to attempt to legislate a mechanism to weed out the incompetence, but also to institute safeguards so that the wrongfully accused will have a way to get out to the extent available through legislation. The question is what are the implications of these concerns for this particular bill and some of the particular provisions in this bill which I would like to address by specific reference.

I may say that my own guide in going through this bill has really been cases that I have worked on, cases in which I have worked administratively and in the courts for physicians--turns out, physicians who, almost without exception, were foreign medical graduates. I don't consider myself a foreign medical specialist. I am prepared to work for any doctor who walks in the door if the case seems to be an appropriate case.

present form, in attempting to deal with that problem, has implications for doctors who are unfairly accused for hidden agendas and the need to build in safeguards which will protect them.

Mr. EDWARDS. Well, your problems also have to do, Mr. Glasberg, with the present system. The present system is inadequate insofar as you are concerned.

Mr. GLASBERG. Well, that is certainly true, sir. Right now all I can do is address the proposed bill here.

Mr. EDWARDS. Very good.

Mr. GLASBERG. The way in which the system works, its unfairness is through denial of procedural due process. No hospital committee is going to expel a doctor for an expressly illegitimate reason of the sort that the witnesses before you are concerned about. They are going to use the loopholes and the vagueness and the various problems with the due process provisions of these kinds of procedures to do that, which is why I fastened on them, as they now use just these types of loopholes common under the current state of affairs, which is basically JCAH-approved bylaws subject to minimal state scrutiny.

Mr. EDWARDS. You want Congress to clean up the situation by taking a bill such as this and inserting into it due process safeguards that would protect physicians?

Mr. GLASBERG. I think that would be a very excellent step, yes,

Mr. EDWARDS. Do you think that this bill could be so amended?

Mr. GLASBERG. I certainly do.

Mr. EDWARDS. And if it were so amended, would you be in favor of it?

Mr. GLASBERG. Yes, sir.

Mr. EDWARDS. Ms. Farray, do you feel the same way, that peer review is important and that we should support and assist such review. Is it your view that this bill is necessary with improvements?

Ms. FARRAY. Yes, sir; I do. After having been a practicing hospital administrator for nearly a decade, I was impressed with the need for a fair and equitable means to review, on a continuing basis, the professional competence of physicians. I feel there is no less need to review the professional competence of minority physicians who take care of the poor. I think the process, however, should be a fair and equitable one.

Mr. EDWARDS. That is very interesting. All three witnesses would be in favor of this type of Federal involvement, but would also agree that the bill should be beefed up with constitutionally appropriate protections. And I think that we will agree that the anti-trust issue has largely been put to rest by, I believe, three circuits; is that correct?

Mr. GLASBERG. So far as I am aware, there is no substantial Federal authority, I think there are one or two cases, suggesting Sherman.

Mr. EDWARDS. I believe I will yield to counsel.

Ms. DAVIS. Thank you, Mr. Chairman.

I would like to address this question to the attorneys on the panel based on your experience with cases challenging peer review.

As I understand it, it is anticipated that as a result of the reporting

all should be disclosed to the public? That is not part of this bill but this was an area where Dr. Wolfe felt the reporting provisions ought to be strengthened.

Mr. GLASBERG. Having heard that first an hour or two ago, I am not sure how fully I can respond on that. Settlements are very often notoriously misleading guides to anything that happened and it is not clear to me that the probative value of a settlement would be the same as that of the other information to be reported.

I think it is an issue that might well be probed and--

Mr. SLOBODIN. Do you think if such a reporting requirement that Dr. Wolfe suggests were adopted in this bill that it would increase litigation, there would be less incentive to settle as is? I think the American Medical Association pointed out that they felt that this would be a problem with some of these tougher reporting requirements. Does that sound realistic at all?

Ms FARRAY. I don't believe so. I think the fact of mounting a suit is something that is very repugnant, in fact, to most physicians. It is a long and costly process both in terms of dollars to them and in terms of the professional reputation and their ability to earn a living.

Also, the fact that a physician is known as having been litigious or mounting a suit at all is not something in their favor in seeking admitting privileges or expanding their practice in most hospitals around the country.

Mr. SLOBODIN. Has there ever been--is anybody on the panel aware of any studies that have been done on states that have shield laws, comparing those states and their experience in trying to curb incompetent practices in the medical profession as opposed to states that don't have the shield laws?

Ms. FARRAY. I am not.

Mr. GLASBERG. Other than what Dr. Wolfe testified to earlier, no.

Mr. SLOBODIN. No further questions.

Thank you, Mr. Chairman.

Ms. DAVIS. I have one further question, Mr. Chairman, and that is you were all very thorough in your comments on the language in the bill. Dr. Wolfe did suggest in his testimony that the breadth of the immunity was limited by the language set out in Section 301, Part 9.

If I am correctly stating his point, if the peer review committee is really used as a subterfuge for some other activity, the immunity will not apply and, therefore, the affected doctor could get damages.

Mr. GLASBERG. The problem is the very nature of the subterfuge, if you will, the hidden agenda is not articulated, so it may very well be the fact that an action would turn out, in the judgment of a jury or in any reasonable person's judgment, to be predicated upon some of the facts set forth in Paragraph 9, but is not presented as such. It is presented on the basis that we reviewed your chart and we found your work isn't any good. Any litigating lawyer, anybody who reads the paper is aware that you can always find a doctor to say anything about anything.

You can get a doctor to say this case was properly done, you can get another doctor to say the case was improperly done, good judgment was exercised, poor judgment was exercised. That is the

The other half of the problem is the fact that the health care profession is, and is becoming even more so every day, a competitive environment. There was a time when there was no thought given, really, to cost containment, where any physician who passed his or her boards was likely to find membership on a medical staff of the choosing of that physician. That no longer is true, and we find that medical staffs are starting to close their membership where they used to be open. Hospitals are finding that they have unfilled beds. There is true competition that is increasing among all levels of health care provision.

Particularly in that environment, it seems to me that the provisions of Title I are extremely dangerous. Let me explain. We have a variety of rights in this country, both as consumers and as practitioners. The bill currently would wipe out very basic fundamental statutes of our country as they apply to health care providers. The civil rights statutes and I am talking about the antitrust laws, and I am talking about as well something that frequently is not addressed in the consideration of these bills, State laws, which have the same kinds of intents.

Now in many States there is either an antitrust act or there is a common law basis for avoiding, and recovering damages in the event of, unfair competition. Likewise, many States have civil rights acts that in some respects go beyond and provide greater protection to members of minorities and nonminorities than is provided by Federal statute. New York has its civil rights act, as do California and a number of other major States.

The bill would make no differentiation among these various protections, and would wipe out what is frequently the only basic right of someone who is an innocent practitioner--I will call the reviewed physician that--under those various

provisions. My concern is for the physician who is wrongfully the target of a peer review action.

I do not think that it can be presumed, as the bill purports to presume, that the action taken in peer review is necessarily for the betterment of health care provision. To the contrary, particularly in light of the increased competition among providers--I am talking about physicians particularly--the likelihood is that that process will be abused for anticompetitive or what I would call antisocial purposes.

The bill, over and above the sweeping policy problems of providing this blanket immunity, also raises substantial doubt as to how it will actually be enforced. That is particularly dangerous in a situation where we are talking about fundamental rights.

I want to digress for one moment. Much has been said, both in these committee proceedings and in the media, about how antitrust suits are abused. Respectfully, I disagree based upon considerable experience, both in and out of the health care profession, representing plaintiffs and defendants in antitrust actions. Congress clearly intended to further antitrust enforcement by private entities, knowing that the Federal Government's resources are limited. That goes both for the FTC and for the Justice Department, and both of those agencies have endorsed the concept of private actions to enforce by supplementation the antitrust laws.

Mr. SEYMOUR. I would agree with the other witnesses but offer an illustration. Presently under the civil rights laws, as well as, I understand, under the antitrust laws, a prevailing defendant may obtain an award of attorneys' fees if the suit is frivolous, vexatious, if it is baseless, or if it is maintained after the plaintiff has reason to understand that it no longer has an adequate basis. Then the defendant under the existing laws can receive an award of attorneys' fees.

The effect of the standard here is to create a right to attorneys' fees where that right would not exist under the civil rights laws. About cases which are fairly arguable, in which there is some substantial evidence the plaintiff was going on, this bill would give a right to defendants to seek fees even where there is good-faith litigation backed up by substantial evidence, and we do not think that is proper. If the case is baseless, there already is a right to recovery on the part of the defendant.

Moreover, in the conduct of the litigation itself, a defendant can seek sanctions under Rule 11, including attorneys' fees, if any part of the litigation is conducted frivolously or vexatiously. There are existing State law rights for abuse of process pursuant to which any of the defendants on these professional review bodies may sue because the lawsuit was frivolously based. So there seems to be no real purpose served by the attorneys' fees provision. No good purpose served by it.

Mr. WEINSTEIN. I would like to add one further comment to that which was just made, and that is very recently the United States Court of Appeals for the Third Circuit, in applying Rule 11 of the Federal Rules of Civil Procedure made it abundantly clear the courts of that circuit are to focus more on the question of the amount of attorneys' fees and other

sanctions to be imposed rather than whether or not to impose the sanctions.

So there is a reawakening by the courts generally, as demonstrated by that case, that the appropriate case can be grounds for sanctions. Whether or not one could recover in fact in a State abuse of process action, the Federal courts are very sensitive to it. Rule 11 was recently in the last few years beefed up, and the courts are responding to that amendment.

Ms. DAVIS. I have one last question and it is in response to testimony heard yesterday, and in our need to understand how peer review has operated thus far. Is it sometimes possible that a physician will be denied privileges because a doctor's patient load has a high proportion of uninsured or indigent persons, and if that is possible, are you convinced that the bill presently is drafted in such a way to prevent that being part of a peer review on the question of competency and professional conduct?

Mr. HALPER. I am sure that, if you are going to deny privileges to anyone, you normally have to follow procedures. The right judgment result is another question. I would suppose someone wanting to process that case against a particular physician under those grounds would use the rubric "quality of care" or something like that, and in that case you probably could have an abuse. It more likely would be an abuse if you leave in the words "professional competency" rather than "quality of care." That was my point earlier. Quality of care is harder to define except in terms of actual

procedures. "Professional conduct" masks a lot of other types of activity.

Mr. WEINSTEIN. And so does professional conduct, whatever that may mean. Yes, I think there is very realistically such a possibility in this day and age where hospitals--leaving apart now physicians--hospitals are concerned about their profitability. We run the risk with this bill that a practitioner is going to have a negative mark reported nationwide merely because of the nature of the population that he or she serves. That is really something that we do not want to encourage.

Ms. DAVIS. Thank you, Mr. Chairman.

Mr. EDWARDS. Counsel.

Mr. SLOBODIN. No questions, Mr. Chairman.

Mr. EDWARDS. Thank you very much, gentlemen. We appreciate your coming here, especially on such short notice and giving such expert testimony. We are very grateful.

The last panel today is composed of Dr. William T. Mixson of Coral Gables, Florida, Immediate Past President of the American College of Obstetricians and Gynecologists, and Dr. W. Michael Byrd, of Tyler, Texas. Dr. Mixson, we welcome you. Without objection, the full statements of both Dr. Mixson and Byrd will he made a part of the record. We welcome you and will hear from Mr. Mixson first.

STATEMENTS OF WILLIAM T. MIXSON, M.D., CORAL GABLES, FLORIDA, IMMEDIATE PAST PRESIDENT, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS; AND W. MICHAEL BYRD, M.D., TYLER TEXAS

Dr. Mixon. Thank you. I am testifying on behalf of the American College of Obstetricians and Gynecologists. I am

particularly pleased to have the opportunity to comment on 5540 because peer review is one of the major planks in my activity last year. I want to commend the members of the committee, and its staff also, for the prompt scheduling of the hearing so that the Congress does have the opportunity to consider this important legislation before adjournment. My written statement covers in detail the college's view on immunity and reporting provisions of H.R. 5540. In the interest of time, I will concentrate on a few points I believe are key to the members of the committee.

Physicians have been told to police bad doctors, to police themselves and get rid of bad doctors. Nobody dislikes bad doctors more than we do. The legitimate physician finds them especially bad. They hurt us all. Our specialty has a long history of self-review and criticism. Maternal mortality committees were born in the 1920s, and as a result of this voluntary peer review, maternal mortality rates have dropped dramatically so that now it is at the lowest level and childbirth is a relatively safe procedure.

We also have continuing peer review activity going on all the time. Quality assurance, tissue committees, transfusion committees, et cetera. These are all part of our everyday professional life. In spite of all of these efforts, we can do better, and we must do better.

* * *

This bill focuses on those instances in which physicians injure patients through incompetent or unprofessional service, are identified as incompetent or unprofessional by their medical colleagues, but are dealt with in a way that allows them to continue to injure patients. The reporting system in this legislation would virtually end the ability of incompetent doctors to skip from one jurisdiction to another without detection.

The limited immunity provided under this bill is essential to encourage physicians and hospitals to participate in conducting effective peer review. The immunity provisions have been restricted so as not to protect illegitimate actions taken under the guise of furthering the quality of health care. Actions that violate civil rights laws or actions that are really taken for anticompetitive purposes will not be protected under this bill.

As floor manager for the bill H.R. 5540, the Health Care Quality Improvement Act of 1986, submits on behalf of the Committee on Energy and Commerce the following comments concerning changes in the bill made subsequent to the filing of the report (99-903, part I) on the bill by the Committee on Energy and Commerce. These amendments were developed largely in response to concerns raised by the Committee on the Judiciary.

AMENDMENT NO. 1

Page 2, line 8, insert "all" after "meets."

This amendment clarifies the requirement that the standards of section 102(a) must be met in full to receive the protections provided under section 101(a).

* * *

AMENDMENT NO. 5

Page 4, line 6, strike "The" and all that follows through "taken" on line 8 and insert: "For purposes of the protection set forth in section 101(a), a professional review action must be taken."

This amendment clarifies that the protections of section 101(a) are available only for professional review actions that meet the standards of section 102(a).

AMENDMENT NO. 6

Page 4, line 13, strike out "due process" and insert "notice and hearing procedures are afforded."

Page 4, line 14, insert before the comma the following: "or after such other procedures as are fair to the physician under the circumstances."

* * *

AMENDMENT NO. 7

* * *

As adopted by the Committee on Energy and Commerce, the legislative language also permitted another unintended interpretation, viz., that the other three standards would have to be pleaded and proved by the defendant as an affirmative defense. Such an interpretation would have shifted the normal burden of proof for civil trials and was never intended by the Committee on Energy and Commerce. (Similarly, nothing in this bill is intended to expand or narrow current discovery rights under State or Federal laws. [*sic*]

This amendment is intended to clarify and simplify the requirements concerning the burden and standard of proof. All four standards are now treated similarly. The standard concerning whether the action was in furtherance of the quality of care still has the benefit of a presumption, but now that presumption is to be overcome by a preponderance of the evidence. Similarly, the amendment now makes clear that the burden of proof with respect to the other three standards is the same as that for subsection 102(a)(1) and rests on the plaintiff, not the defendant or defendants.

* * *

AMENDMENT NO. 10

* * *

Page 23, line 13, before the period add the following:

"(E) the intent to retaliate illegally against a physician who, prior to the commencement of an investigation regarding the physician's competence or professional conduct, raised legitimate questions regarding the quality of health care of the health care entity, or

"(F) any other matter that does not relate to the competence or professional conduct of a physician."

This amendment clarifies the exclusions from matters that can be considered to be related to the competence or professional conduct of a physician. The change in paragraph (B) is to clarify that actions taken to enforce illegal price-fixing arrangements are not protected under the bill.

New paragraph (E) makes explicit that professional review actions taken in retaliation against whistleblowers are not protected under the bill. This exclusion is in response to concerns raised by a witness before the Judiciary Committee's Subcommittee on Civil and Constitutional Rights about the problems facing whistleblowers in some hospitals. It is not

intended to create a safe haven for incompetent or unprofessional physicians who seek to fend off legitimate professional review actions by suddenly questioning the competence or professional conduct of others. To qualify for this exclusion, a physician must convince a court that the professional review action was commenced after the physician had raised legitimate charges against the health care entity, and was initiated illegally in retaliation for the physician's having done so.

New paragraph (F) is intended to clarify that the list of exclusions is not exhaustive. This subsection reflects the concern that professionals review actions brought for illegitimate reasons may not appear as such on their face. Actions which specify, for example, that they are based on a physician's fees, or actions brought against a nonphysician practitioner, are clearly not eligible for protection under this bill. The more serious issues arise when actions are stated to be for legitimate reasons, but are challenged as not being genuinely based on the competence or professional conduct of an individual physician. It is, of course, the plaintiff physician's burden of pleading and proving to the court that the action was based on matters that do not relate to the physician's competence or professional conduct. The purpose of paragraph (F) is simply to avoid the interference that any matters not listed in this subsection are necessarily ones related to competence or professional conduct. For example, actions based solely on competitive considerations other than the ones enumerated in the bill would not qualify as being based on professional conduct or competence. For example, an action taken against a physician because of a style of practice or a pattern of patients that does not general sufficient revenue for a hospital would not be covered by this bill.

On the other hand, competence and professional conduct should be interpreted in a way that is sufficiently broad to

protect legitimate actions based on matters that raise concerns for patients or patient care. It would certainly include all specific conduct that could adversely affect the health or welfare of a patient or patients. This would include not only activities directly involving patients of the physician but also activities that raise the possibility of adversely affecting other patients. Such activities clearly would encompass felonies or crimes of moral turpitude. They would also include illicit transactions involving drugs, serious sexual offenses, violent behavior, and other similar acts.

Mr. Edwards of California.

* * *

Mr. Speaker, each one of our witnesses agreed that more effective physician peer review should and must be encouraged. But they unanimously agreed that the bill fails to adequately protect competent physicians from abusive actions by illegal professional review. In light of the Judiciary Committee's review, the chairman of the Subcommittee on Health and the Environment has made some significant changes to improve this bill; however, the fundamental flaw of the bill in its present form continues to be that the immunities shield professional actions which are fair as well as actions which are illegal.

COMMITTEE ON THE JUDICIARY.
Washington, D.C., October 10, 1986

Henry A. Waxman,
House Annex 1,
Washington, D.C.

Dear Henry: On September 29, the Judiciary Committee obtained a sequential referral of H.R. 5540, the "Health Care Quality Improvement Act of 1986." The initial referral ran through October 3. The referral was subsequently extended until Tuesday, October 14.

The bill was referred to the Subcommittee on Civil and Constitutional Rights to consider issues raised by the bill that fall within the jurisdiction of the Judiciary Committee. The Subcommittee just concluded two days of hearings on the bill. It was our intention in holding these hearings to provide a more complete record on the implications of the immunities and due process provisions set forth in Title I of H.R. 5540.

Our review would thus augment the hearing held on July 15, 1986 by the Subcommittee on Health and Environment.

* * *

The several witnesses presenting testimony to Judiciary were physicians (3), attorneys (6) and quality health care advocates (3) who are familiar with the peer review process. Each witness agreed that effective review of physicians is necessary to assure the delivery of competent, quality health care to all Americans. However, they stressed that the privileges of physicians should not be adversely affected through professional review action for reasons unrelated to competency. They agreed that the bill, as reported, does not provide adequate protections to competent physicians from abusive actions by illegal professional review.

* * *

The legal and constitutional problems created by this bill are many. We will summarize the most serious examples which were revealed during the Judiciary Committee's review of H.R. 5540. We found:

* * *

2. The bill establishes a statutory presumption that professional review actions are in the "furtherance of quality health care." It is a presumption which can only be overcome by "clear and convincing evidence." The presumption and burden of proof subvert existing law, with no compelling justification. Moreover, they would simply create additional legal issues to litigate in suits challenging review actions. A three-tiered system would result: one trial for injunctive relief, with one set of presumptions and burdens of proof and one trial to challenge the validity of the peer review action, with a different set of presumptions and burdens. If a physician were successful in the second suit, there would then be a third suit for damages. Such an approach is legally unsound, will add significant legal costs for both sides in an already costly proceeding, and frustrate the very purpose of the bill --

effective peer review through voluntary reporting.

* * *

We urge you to accept the findings and recommendations of the Committee on the Judiciary.

With kind regards.

Sincerely,

Don Edwards
Chairman, Subcommittee on Civil and Constitutional Rights.

* * *

Second the bill includes the provisions of the Health Care Quality Improvement Act, also passed by this House this week by voice vote. This bill is noncontroversial and has strong bipartisan support.

Mr. Speaker, the following comments pertain to title, this is title IV of the bill, which incorporates a modified version of H.R. 5540, the "Health Care Quality Improvement Act of 1986." H.R. 5540, as amended, passed the House on October 14.

These provisions have undergone a number of revisions during the legislative process. I stress this because most of the objections that were raised about earlier versions of H.R. 5540 (and its predecessor, H.R. 5110) have been addressed in recent drafts, and particularly in the provisions that are now before the House.

I would specifically note that my distinguished colleague from California, Don Edwards, the chairman of Judiciary's Subcommittee on Civil and Constitutional Rights, inserted his thoughtful letter of October 10 to me, and I would now insert a number of quotes from my response of October 14 to that letter. This is quite relevant since numerous revisions to the bill were made in response to the concerns raised in that letter. In addition, the bill that is now before us includes a number of other revisions worked out with the Senate. These changes--resulting in the final bill--address the remarks of Mr. Edwards.

* * *

BREADTH OF IMMUNITY

At one point, the scope of immunity in this bill was substantially broader than it is currently, in response to a number of valid criticisms, we narrowed the bill's scope in order to ensure that the jurisdiction of the Federal Trade

Commission, the Justice Department, the Equal Employment Opportunity Commission and State attorneys general remained intact. Furthermore, the only protection with regard to private actions is that damages are barred where the peer review group has acted properly in accordance with the four tests for reasonable belief, reasonable investigation and due process. Actions for reinstatement through injunctive and declaratory relief remain untouched. Finally, by the latest changes in H.R. 5540, we have completely removed from coverage any Federal or State civil rights laws. The immunity left after these modifications is extremely limited, but essential....

IMPLICATIONS OF THE REVERSAL OF PATRICK VERSUS BUGET [*sic*]

* * *

Nevertheless, I would make the following point with respect to the Patrick case and the antitrust laws. It is my understanding that a number of antitrust experts believe that the Ninth Circuit has extended the State action doctrine in Patrick farther than seems warranted by recent Supreme Court rulings. If appealed, the Patrick case may well be overruled or modified. If Patrick is upheld, the immunity from damages in antitrust actions granted by H.R. 5540 will be irrelevant in many States. If Patrick is overruled or modified, the immunity obtained under H.R. 5540 will be substantially narrower than the State action doctrine enunciated in that case. Bad faith peer review activities permitted by the Patrick case could never obtain immunity under H.R. 5540.

Finally, the immunity contained in H.R. 5540, although promoted in part by antitrust concerns, addresses matters beyond the current antitrust laws. The reporting system in the bill is likely to stimulate a large number of lawsuits raising numerous legal theories -- many of them frivolous -- that will deter legitimate peer review activities unless some measure of protection is provided to those engaged in such activities.

* * *

NEED FOR A PRESUMPTION BASED ON CLEAR AND CONVINCING EVIDENCE

You object to the presumption regarding professional review actions that requires clear and convincing evidence. You suggest that it would create needless complexity in the minds of a jury to apply different standards, thereby adding to the

confusion and potential delay of a peer review trial in court.

Although I believe that the provisions of H.R. 5540, as drafted, are sound, I have modified the presumption to substitute the clear and convincing evidence test with a preponderance of the evidence test and to apply it uniformly. Such a step should simplify the immunity provisions and

---

make them easier to understand and apply.

* * *

§ 11112 Standards for professional review actions

(b) Adequate notice and hearing

A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating -

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing

If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating -

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice

If a hearing is requested on a timely basis under paragraph (1)(B) -

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) -

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right -

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right -

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section.